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ABSTRACT

This document reports on the feasibility of requiring private insurance carriers to provide coverage of the pregnancy-related expenses of dependent minors and newborn care expenses of their offspring in Texas. The document relates the history of legislative interest in the topic of teenage pregnancy. The report states that although private medical insurance does not usually cover normal pregnancy and delivery, the major problem exists for pregnant teenagers in low income groups who have no insurance. The report gives characteristics of pregnant teenagers, including incidence of marriage, live birth, out-of-wedlock births, abortions, and birth complications. Pregnancy related services and costs are discussed including family planning, abortion, live births, pregnancy complications, newborns, and payment sources. The results of a survey of private insurance carriers and of laws in other states are given. Tables and appendices provide data results. Nine pages of references are also included. (ABL)

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ED266343

# A Report from The State Board of Insurance to the 69th Texas Legislature 1985

CG 018823

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# INTRODUCTION

During the interim between the 1981 and 1983 sessions of the Texas Legislature, the Texas House of Representatives Select Committee on Teenage Pregnancy was directed to investigate the problems associated with teenage pregnancies in the State of Texas and to examine policies and programs designed to deal with those problems. Throughout 1982, the Committee conducted research on the issue of teenage pregnancy in Texas and held numerous public hearings across the state. The findings of the committee contained ten recommendations for legislative consideration and were forwarded to the 68th Legislature in October 1982.[1]

Recommendation Five of the report discusses the economic impact of adolescent pregnancies upon the families of pregnant teens and the importance of health care services to these minors and their offspring in ensuring an optimal pregnancy outcome.[2] The study found that women who bear children in their teens are often unmarried and still dependent upon parental assistance. Their pregnancies are also more often associated with complications than are those of older women.

The interim report states most private health insurance does not cover the pregnancy expenses of dependent minors unless complications requiring hospitalization occur.[3] (Texas law requires that complications of pregnancy be covered under all accident and health policies.) As a consequence, prenatal care, normal deliveries, and the medical care expenses of the newborn child (i.e., the grandchild of the policyholder) would not be covered. As a result of these findings, the Committee concluded that the pregnant teen's family must cover costs out-of-pocket or the teen mother must seek public assistance to pay for the pregnancy.

To address these concerns, the Committee included in its report a recommendation that the State Board of Insurance be directed to investigate the feasibility of requiring private insurance carriers to provide coverage of the pregnancy-related expenses of dependent minors and newborn care expenses of their offspring. Subsequently, House Concurrent Resolution (HCR) 84 of the 68th Legislature was enacted, directing the State Board of Insurance to conduct a feasibility study for presentation to the 69th Legislature. Areas of concern in the Select Committee's report and in HCR 84 are that any proposed private insurance coverage should:

- "be available regardless of who pays the premium;
- include all pregnancy-related costs, including hospitalization and outpatient prenatal expenses;
- extend to newborn grandchildren of policyholders for the first 30 days of life, as does coverage of newborn children of policyholders; and
- be available whether or not the child is placed for adoption." (See Appendix A.)

The interest in Texas in the problems of teen mothers' health care needs comes at a time when the state is faced with serious problems in the delivery of health care services to the poor. In 1984, a Texas Task Force on Indigent Health Care was formed to do an in-depth review of the problem and to develop possible solutions. In its final report, the Task Force states that maternity services have been identified as the top priority health care service for indigents in Texas. This finding illustrates the importance of adequate care in assuring a healthy pregnancy and a healthy baby. However, the report goes on to state that "to a

considerable degree, lack of adequate health insurance defines who is medically indigent." Thus it would appear that many of the indigent teenage mothers are in such a financial position not because their insurance policies do not cover the costs of pregnancy, but because they simply do not have any health insurance.

The request that this study be conducted was made under the assumption that private insurance, where existing, does not cover the pregnancy expenses of dependent minors or the related expenses of their newborn offspring. This assumption is contained in the Interim Report as follows:

> "Most private medical insurance providers do not cover pregnancy and delivery to the dependent minors of policyholders unless there are pregnancy complications requiring hospitalization. Under no circumstances is the grandchild covered, regardless of his or her medical needs."4

However, the results of a survey conducted by the State Board of Insurance of private insurance carriers and Health Maintenance Organizations licensed in Texas reveal that dependent minor pregnancy insurance is, in fact, available. Newborn care for the offspring of dependent minors is not, however, as widely covered (see Chapter 4). In addition, two studies on the source of payment for adolescent deliveries lead one to question the significance of private insurance as a resource for teenage pregnancy expenses. These studies offer some possible explanation for the Select Committee's assumption concerning the lack of available coverage.

To understand more completely the perception of a lack of coverage one must take into consideration the limited extent of the role of insurance in providing health insurance coverage for teen mothers generally. Because teen pregnancies predominate among low income groups who are less likely to be insured, the relatively small role played by private insurance is explained. These findings would suggest that responsibility for payment of teenage pregnancy costs is perhaps not an issue of the provisions contained in private insurance policies, but is instead a question of access to private insurance. This issue is discussed later in the report but should be kept in mind when considering the possible effectiveness of insurance in dealing with this problem.

As explained in HCR 84, the main purpose of this study is to examine the role that private health insurance might play in providing for the health of the teenage mother and her infant in averting financial hardships upon the families of pregnant teenagers. The process of making this assessment first involves an examination of the characteristics of the pregnant teenage population (particularly the unmarried dependent minor), including the health factors associated with adolescent pregnancy and the role of the family in providing for dependent daughters. Chapter One analyses the demographics of the teenage pregnancy population and includes discussion on premarital pregnancies and marriage among teen women. Chapter Two examines the medical care and expenses involved in regard to teenage pregnancies with a brief look at the role of the family, the public, and private insurers in paying these expenses.

Chapter Three examines in depth the provision of care through private insurance resources. In particular, this chapter looks at private insurance policies and practices concerning dependent minor pregnancy-related coverage and newborn care coverage

based on findings of a survey conducted by the State Board of Insurance. Also included is a discussion of the principles and practices of insurance, statutory and regulatory provisions for maternity care and newborn care, the present status of private insurance coverage, and cost estimates for this type of insurance. And, finally, Chapter Four ends the report with some general observations and conclusions.

Footnotes

[1] Texas House of Representatives, Select Committee on Teenage Pregnancy, Interim Report to the 68th Texas Legislature, Select Committee on Teenage Pregnancy, October 1, 1982, 121-147.

[2] Ibid., 139.

[3] Ibid., 32.

[4] Texas House of Representatives, Select Committee, Interim Report, 32.

## CHAPTER 1

## CHARACTERISTICS OF THE TEENAGE PREGNANCY POPULATION

In Texas in 1980, more than 90,000 women aged 19 or younger became pregnant. Of this total, 49,093 resulted in live births, an estimated 29,730 were terminated by abortion, and an estimated 13,000 ended by miscarriage. Table 1.1 shows estimates for the total number of teenage pregnancies in 1980.

In 1982, there were 50,585 live births to Texas teenage women. Among the 665,345 Texas women who are 15-19, roughly one in nine became pregnant. Nationally, one in ten teenage women became pregnant. Texas has the fifth highest teenage pregnancy rate in the country, behind Washington, D.C., Arkansas, California, and Nevada.[1]

Contrary to public opinion, there has not been an epidemic growth in recent years in the number of births to teen women. In 1973, there were 616,957 births in the United States to women under 20; in 1980, there were only 562,000.[2] This is significant given the increase from 1973 to 1980 in the number of teenage women--nationally, an increase in the number of 15-19 year old women from approximately 9.5 million to 10.4 million.[3] In Texas, the 15-19 year old female population increased from 538,538 to 665,345. However, the increased use of abortion hides the fact that there has been an increase in the total number of teenage pregnancies (i.e., births, abortions, and miscarriages). From 1973 to 1980, years in which the most reliable abortion estimates are available, there was an increase from 232,440 to 444,780 in the number of abortions among teenage women.[4] Thus, the actual number of teenage pregnancies did increase from 849,397 in 1973 to 1,006,780 in 1980.

Table 1.1

Resolution of Pregnancy
Teenage Mothers
Texas, 1980

| Age of Mother | Total Pregnancies | Live Births | Abortions* (estimates) | Miscarriages** (estimates) |
|---|---|---|---|---|
| Under 15 | 2,232 | 998 | 940 | 294 |
| 15 | 5,556 | 2,888 | 1,900 | 768 |
| 16 | 11,655 | 5,954 | 4,100 | 1,601 |
| 17 | 18,132 | 9,729 | 5,870 | 2,533 |
| 18 | 25,398 | 13,502 | 8,360 | 3,536 |
| 19 | 29,840 | 17,020 | 8,560 | 4,260 |
| 15-19 | 90,581 | 49,093 | 28,790 | 12,698 |
| Total Under 20 | 92,812 | 50,091 | 29,730 | 12,991 |

* Number of abortions based upon estimates of the Alan Guttmacher Institute (AGI), Abortion Survey and Center for Disease Control Abortion Surveillance, Annual Summary, 1980, Atlanta, 1983

** Number of miscarriages based upon calculations of Tietze and Bongaarts (20% of live births + 10% of abortions = number of miscarriages)

Sources:
(Live Births) Texas Department of Health, Bureau of Vital Statistics, "Live Births by Place of Residence, 1980,"

(Abortions) The Alan Guttmacher Institute, Stanley Henshaw, phone interview, March 1984, data collected via The Alan Guttmacher Institute Survey and the Center for Disease Control, Abortion Surveillance, Annual Summary, Atlanta, 1983.

The number of teen pregnancies includes live births and abortions but excludes miscarriages and stillbirths. There is no evidence that the incidence of miscarriages and stillbirths has changed over this period and thus no trend will be reflected. However, the population at risk (i.e., the number of females in this age group and the percentage of sexually active teen women) has also increased, thus indicating that other factors (e.g., sexual education, contraceptive practices) may have had an effect on the incidence of teenage pregnancy.

Teenage pregnancies are a continuing problem, not only due to their numbers, but also because of their characteristics. Out-of-wedlock births, health complications, abortion utilization, adolescent sexual activity and the long-term social and financial consequences of unplanned and unwanted births are the primary problems most often associated with teenage pregnancy. This chapter will look at some of these issues and how teenagers and their families are affected.

Throughout this report, standard age classifications will be used in discussing the teenage pregnancy population. Due to the nature of the problems associated with teen pregnancies at different age levels and for purposes of comparison, the study will use three different categories unless otherwise noted: (1) females aged 14 and younger, (2) females aged 15-17, and (3) females aged 18-19.

## Incidence of Marriage

Since the purpose of this study is to determine insurance practices with regard to pregnant minors, it is particularly important to consider the proportion of teenage women who become pregnant and yet remain unmarried and dependent upon their families for support, which may or may not include health

insurance benefits. A series of important studies were conducted from 1971 to 1979 on teenage sexuality, contraception, and pregnancy. A study of first pregnancies among teenage women reports that the proportion of premaritally pregnant teenage women rose from 8.5 percent in 1971 to 16.2 percent in 1979. However, during this same period, the number of pregnant teen women who chose to marry declined from 32.7 percent in 1971 to 15.5 percent in 1979.[5] The study further found that white teen women were more likely to opt for marriage before the resolution of the first pregnancy than were black teens; 20.3 percent of whites did so, whereas only 4.3 percent of black teens took this route. However, a significant number of teen women of both races remained unmarried before resolution of the pregnancy -- 79.7 percent of white teens and 95.7 percent of black teens in 1979.

Among teen women 15-19 years of age who remained unmarried at the time of the resolution, (i.e., live birth, abortion, or miscarrage), approximately half of their pregnancies resulted in live births and more than a third in abortion.[6] However, from 1971 to 1979, abortion was increasingly chosen as a resolution path. In 1971 (when elective abortion was still illegal in most places), 23.4 percent of premarital first pregnancies among teens were aborted; in 1979, 36.6 percent resulted in induced abortions.

Though numerous studies have explored the question of why a pregnant woman decides to marry or not, there is no clear answer. Possible explanations include the teen woman's perception of the reliability of the father, as well as his willingness to enter into marriage. The teen woman also may be reluctant to forego parental assistance, given that marriage may cut important family ties--particularly financial ties, which, again, may include insurance benefits. An additional reason might be a desire to retain eligibility for public assistance, which would, in most cases, be lost in the event of marriage.[7]

## Live Birth Statistics

The decision of a teen woman to carry her pregnancy to term also entails--in the vast majority of cases--a decision to keep the baby. Few teen mothers place their infants for adoption. In 1982, 17 percent of live births in Texas were to teenage women. There has been only a slight increase in the absolute number of births to teen women despite the rapid increase in the number of Texas women in this age bracket. From 1970 to 1982, the number of 15-19 year old women increased from 538,538 to 665,345. In 1970, there were 46,513 live births to Texas teenage women; in 1982, there were 50,585 births among teenagers (see Table 1.2). Eighteen and 19 year old teenage mothers accounted for 62 percent of teen births in 1982; 15-17 year old mothers represented 35.8 percent of total teen births.

From 1970 to 1982, there was an increase from 954 to 1,089 in the number of live births to teen women under 15 years of age. These small increases are significant given the large increases in the teenage female population. In 1970, there were 886,060 teenage women 12-19 years old (very few births occur among adolescents younger than 12); in 1982, the female population in this age bracket had risen to 1,027,515. (See Table 1.3 for historical statistics on the teenage female population.)

Distribution of teen pregnancies varies somewhat by race and ethnicity. In 1982, white teens represented 59 percent of the 15-19 year old teen population; 44 percent of teen births in this age bracket were to white females. Black teenage women represented 14 percent of the 15-19 year old teenage population in 1982 and 20 percent of births to teens. Hispanic women accounted for 27 percent of 15-19 year olds and 36 percent of teen births (see Table 1.4).

Table 1.2

Live Births
Ages Under 15, 15-17, 18-19,
Texas 1970-1982

| | Under 15 | 15-17 | 18-19 | Total Under 20 |
|---|---|---|---|---|
| 1970 | 954 | 17,053 | 28,506 | 46,513 |
| 1971 | 1,009 | 17,977 | 28,947 | 47,933 |
| 1972 | 1,025 | 18,708 | 28,011 | 47,744 |
| 1973 | 1,133 | 19,084 | 27,292 | 47,509 |
| 1974 | 1,120 | 18,765 | 26,997 | 46,882 |
| 1975 | 1,084 | 18,626 | 27,252 | 46,962 |
| 1976 | 1,077 | 18,051 | 26,815 | 45,943 |
| 1977 | 1,061 | 18,118 | 26,403 | 45,582 |
| 1978 | 1,068 | 17,841 | 27,419 | 46,328 |
| 1979 | 1,071 | 17,947 | 28,739 | 47,757 |
| 1980 | 998 | 18,571 | 30,522 | 50,091 |
| 1981 | 987 | 18,067 | 30,698 | 49,752 |
| 1982 | 1,089 | 18,129 | 31,367 | 50,585 |

Source: Texas Department of Health, Bureau of Vital Statistics, "Live Births By Place of Residence, 1970-1982."

Table 1.3

Female Population, Live Births, and Fertility Rates,
By Ages 12-14, 15-19, 20-24,
TEXAS, 1970 - 1982

| | 12 - 14 | | | 15 - 19 | | | 20 - 24 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Population | Live Births | Fert. Rate | Population | Live Births | Fert. Rate | Population | Live Births | Fert. Rate |
| 1970 | 347,522 | 950 | 2.7 | 538,538 | 45,559 | 84.6 | 484,457 | 90,106 | 185.9 |
| 1971 | 345,492 | 1,007 | 2.9 | 546,643 | 46,924 | 85.8 | 499,939 | 88,545 | 177.1 |
| 1972 | 343,722 | 1,023 | 2.9 | 555,242 | 46,719 | 84.1 | 515,253 | 79,757 | 154.5 |
| 1973 | 342,380 | 1,127 | 3.3 | 564,520 | 46,376 | 82.2 | 533,630 | 75,863 | 142.2 |
| 1974 | 341,523 | 1,119 | 3.3 | 574,537 | 45,762 | 79.7 | 552,144 | 76,366 | 138.3 |
| 1975 | 341,175 | 1,082 | 3.2 | 585,388 | 45,878 | 78.4 | 571,915 | 77,164 | 134.9 |
| 1976 | 341,492 | 1,074 | 3.1 | 597,322 | 44,866 | 75.1 | 593,217 | 77,645 | 130.9 |
| 1977 | 342,494 | 1,059 | 3.1 | 610,425 | 44,521 | 72.9 | 616,182 | 81,747 | 132.7 |
| 1978 | 344,342 | 1,066 | 3.1 | 625,064 | 45,260 | 72.4 | 641,154 | 83,785 | 130.7 |
| 1979 | 347,385 | 1,065 | 3.0 | 641,740 | 46,686 | 72.7 | 668,615 | 89,392 | 133.7 |
| 1980 | 352,075 | 996 | 2.9 | 661,321 | 49,093 | 74.2 | 699,278 | 96,105 | 137.4 |
| 1981 | 356,897 | 992 | 2.8 | 662,886 | 48,765 | 73.6 | 696,776 | 98,380 | 141.2 |
| 1982 | 362,170 | 1,084 | 3.0 | 665,345 | 49,496 | 74.4 | 695,159 | 103,475 | 148.9 |

Source: (Live Births) Texas Department of Health, Bureau of Vital Statistics, "Live Births By Place of Residence, 1970-1982."
Texas Department of Health, Population Data System, State Health Planning and Resource Development, 6/22/83. (Population)

Table 1.4

Live Births Among Teen Women
Under 15, 15-17, and 18-19 Years Old,
by Race/Ethnicity, Texas 1982

| | Total Births | Number and Percentage of Total Births By Race/Ethnicity | | |
|---|---|---|---|---|
| | | White | Black | Hispanic |
| Under 15 | 1,089 (100%) | 234 (21%) | 415 (38%) | 440 (40%) |
| 15 - 17 | 18,129 (100%) | 6,801 (38%) | 4,187 (23%) | 7,141 (39%) |
| 18 - 19 | 31,367 (100%) | 14,953 (48%) | 5,638 (18%) | 10,776 (34%) |
| Total | 50,585 (100%) | 21,988 (44%) | 10,240 (20%) | 18,357 (36%) |

Source: Texas Department of Health, Bureau of Vital Statistics "Live Births By Place of Residence, 1982."

## Out-of-Wedlock Births - Dependent Minor Teen Mothers

In 1982, there were 17,512 out-of-wedlock births among Texas teenage women, which represents an increase from 1970, when there were 11,105 out-of-wedlock births to teens (see Table 1.5). Out-of-wedlock births have increased as a percentage of all teen births, from 23.9 percent of the total in 1970 to 34.6 percent in 1982. This may indicate that teen mothers who carry their pregnancies to term are turning to marriage less often as a resolution option. Marriage, of course, usually results in the teen mother losing her dependency status under her parent's(s') health insurance.

Age of the teen mother is an important indicator of dependent minor status because the younger the teen, the less likely she is married and the more likely she is dependent upon her family. In 1982, of the 31,367 births to women 18-19, 27.4 percent were out-of-wedlock. However, 44.6 percent of births among 15-17 year old teens were out-of-wedlock. Most mothers younger than 15 are unmarried; in 1982, 74.7 percent of their children were born out-of-wedlock (see Table 1.6).

A disproportionate number of out-of-wedlock births are to minority teens. In 1982, 45.4 percent and 25.7 percent were, respectively, to black and Hispanic teens. In addition, the younger the unmarried teen mother, the more likely she was black or Hispanic. In 1982, among out-of-wedlock teen mothers under 15, 49.6 percent were black, 20.7 percent were white, and 29.6 percent were Hispanic. However, among 18-19 year old out-of-wedlock teen mothers, 45.1 percent were black, 30.3 percent were white, and 24.6 percent were Hispanic.

Table 1.5
Out-of-Wedlock Births Among Teen Women, Texas 1970-1982

| | Number | As % of Teen Births | As % of All Out-of-Wedlock Births | Number and As % of Total Number White | Black | Hispanic |
|---|---|---|---|---|---|---|
| 1970 | 11,105 | 23.9 | 51.3 | 4,892 | 6,213 | * |
| 1971 | 11,969 | 24.9 | 51.3 | 4,986 | 6,983 | * |
| 1972 | 13,004 | 27.2 | 53.0 | 5,386 | 7,618 | * |
| 1973 | 13,501 | 28.4 | 53.5 | 5,581 | 7,650 | * |
| 1974 | 13,433 | 28.6 | 53.8 | 5,889 | 7,544 | * |
| 1975 | 14,386 | 30.6 | 54.6 | 6,546 | 7,840 | * |
| 1976 | 14,460 | 31.4 | 53.5 | 6,830 | 7,630 | * |
| 1977 | 14,728 | 32.3 | 51.2 | 7,009 | 7,719 | * |
| 1978 | 15,368 | 33.1 | 49.3 | 4,417 (28.7%) | 7,808 (50.8%) | 3,413 (22.2%) |
| 1979 | 16,024 | 33.5 | 47.4 | 4,340 (27.0) | 8,094 (50.5) | 3,590 (22.4) |
| 1980 | 16,780 | 33.5 | 46.1 | 4,732 (28.2) | 8,145 (48.5) | 3,903 (23.2) |
| 1981 | 16,795 | 33.7 | 44.2 | 4,864 (28.9) | 7,857 (46.8) | 4,074 (24.2) |
| 1982 | 17,512 | 34.6 | 42.3 | 5,059 (28.9) | 7,951 (45.4) | 4,502 (25.7) |

* Spanish surname births not reported separately during these years

Source: Texas Department of Health, Bureau of Vital Statistics
"Live Births by Place of Residence, 1970-1982 Unmarried Mothers."

Table 1.6

Out-of-Wedlock Births, By Age, By Race/Ethnicity, Texas 1982

| | Total Births (Married and Unmarried) | Out-of-Wedlock Births (Number, as Percent of Total By Race/Ethnicity) Total | | White | | Black | | Hispanic | |
|---|---|---|---|---|---|---|---|---|---|
| | | # | % | # | % | # | % | # | % |
| Under 15 | 1,089 | 814 | 100.0% | 169 | 20.8% | 404 | 49.6% | 241 | 29.6% |
| 15-17 | 18,129 | 8,094 | 100.0 | 2,285 | 28.2 | 3,666 | 45.3 | 2,143 | 26.5 |
| 18-19 | 31,367 | 8,604 | 100.0 | 2,605 | 30.3 | 3,881 | 45.1 | 2,118 | 24.6 |
| Total 19 and Under | 50,585 | 17,512 | 100.0 | 5,059 | 28.8 | 7,951 | 45.4 | 4,502 | 25.7 |
| 20-24 | 103,475 | 14,459 (13.9% out-of-wedlock) | 100.0 | 4,228 | 29.2 | 6,403 | 44.2 | 3,828 | 26.4 |
| Total All Ages | 297,683 | 41,421 (13.9% out-of wedlock) | 100.0 | 11,810 | 28.5 | 18,080 | 43.6 | 11,531 | 27.8 |

Source: Texas Department of Health, Bureau of Vital Statistics, "Live Births by Place of Residence, 1982 Unmarried Mothers."

## Abortions

The Alan Guttmacher Institute and the Center for Disease Control--two of the most comprehensive sources of abortion data--estimate that in 1980 (the most recent year for which statistics are available) there were 29,730 teenage abortions in Texas (see Table 1.7).

A significant number of teenage pregnancies are not carried to term but rather end in abortion. Abortion is a widely chosen option among teenage women because a significant number of their pregnancies are unintended and/or unwanted. A greater proportion of teenage women who become pregnant are unmarried (i.e., dependent minors), in which case they are less likely to carry the pregnancy to term. In 1980, approximately 79 percent of abortions were obtained by unmarried women.[8]

In 1980, approximately 30 percent of all abortions were obtained by teenage women.[9] Of the teens who were pregnant that year, an estimated 40.5 percent (excluding pregnancies ending in miscarriages/stillbirths) chose to resolve this pregnancy by abortion. In comparison, only 29.9 percent of pregnancies among women 20-24 ended in abortion.

Since the legalization of on-demand first trimester abortions under Roe v. Wade 410 U.S. 113 (1973), the number of abortions among all women has risen significantly. For women of all ages, the U.S. total is estimated to have increased from 744,610 in 1973 to 1,553,890 in 1980 (see Table 1.8).[10] Following the overall trend, an increasing number of teenage pregnancies are ending in abortion. From 1973 to 1980, it is estimated that the number of teenage abortions rose from 232,440 to 440,780.

Table 1.7

Estimated Number of Abortions Obtained by Texas Teens, 1980

| Age | Estimated Number of Abortions |
|---|---|
| Under 15 | 940 |
| 15 | 1,900 |
| 16 | 4,100 |
| 17 | 5,870 |
| 18 | 8,360 |
| 19 | 8,560 |
| Total: | 29,730 |

Source: The Alan Guttmacher Institute, Stanley Henshaw, phone interview, March 1984, data collected via The Alan Guttmacher Institute Survey and the Center for Disease Control, Abortion Surveillance, Annual Summary, Atlanta, 1983.

## Complications of Birth: Maternal Morbidity and Infant Mortality/Morbidity

Teenage pregnancies, relative to pregnancies among women 20-24 years of age, are characterized by a higher degree of complications, including low birth weight babies (which is symptomatic of congenital malformations and neonatal deaths), infant mortality, and maternal complications (including toxemia and anemia for the teenage mother). The reasons for these more frequent difficulties include poor nutrition, lack of medical care (particularly prenatal care), and the immaturity of the teen mother's physical development.

The most common complications of pregnancy affecting teenage mothers are toxemia, prolonged labor, and iron-deficiency anemia. The Alan Guttmacher Institute reports that teenage mothers are 15 percent more likely to suffer from toxemia and 92 percent more likely to have anemia than mothers 20-24 years of age.[11] Premature birth complications were 23 percent more likely among young mothers. The disproportionate existence of pregnancy complications, as they effect the teenage mother, extends to higher rates of infant morbidity and mortality. The neonatal death rate is greater the younger the mother. The neonatal death rate decreases as the age of the mother increases, from a 12.2 per 1,000 rate for mothers under 15 to a 7.3 per 1,000 rate among mothers in the 20-24 age bracket. (See Table 1.8).

Low Birth Weight: Low birth weight (i.e., less than 2500 grams or 5.5 pounds) is highly correlated with infant mortality as well as developmental problems for the infant.[12] The poor nutritional and medical care practices of teen women seem to be directly related to low birth weight. As Chapter 2 will discuss, the receipt of prenatal care shows an effect on reducing the incidence of low birth weight babies.

Table 1.8

Neonatal Deaths By Age of Mother
Texas Residents, 1981

| Age of Mother | Number Live Births | Neonatal Deaths* Number | Rate |
|---|---|---|---|
| 15 | 987 | 12 | 12.2 |
| 15 - 17 | 18,067 | 186 | 10.3 |
| 18 - 19 | 30,698 | 249 | 8.1 |
| 20 - 24 | 98,380 | 721 | 7.3 |
| 25+ | 133,341 | 838 | 6.3 |
| Unspecified | 85 | 4 | 0.0 |
| Total | 281,558 | 2,010 | 7.1 |

* Neonatal - 0 to 27 days after birth (deaths per 1000 live births)

Source: Texas Department of Health, Bureau of Vital Statistics, Linked Birth and Death Statistical File, 1981

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section.

In Texas in 1982, 9.5 percent of 15-17 year old live births were low birth weight; 8.5 percent and 6.8 percent of, respectively, 18-19 and 20-24 year old live births were low birth weight. The highest rate of low birth weight babies was among mothers under 15: 13.4 percent (see Table 1.9). Black teen mothers are more likely to bear low birth weight babies than are white and Hispanic teen mothers. Among 15-17 year olds, the rate was 13.8. However, the white and Hispanic rates were, respectively, 8.5 and 8.0. A similar trend exists among mothers of all ages. Among 18-19 year olds, 13.9 percent of black mothers bore low birth weight babies; the white and Hispanic rates were, respectively, 7.3 percent and 7.2 percent.

A significant difference also exists between the incidence of low birth weight and the marital status of the mother. As Table 1.11 shows, 11.3 percent of unmarried mothers under 20 bore low birth weight babies, as compared to 7.5 percent for married teen mothers. Among 15-17 year old mothers, the low birth weight rate was 8.0 percent for married mothers but 10.0 percent for unmarried mothers. Unmarried mothers under 15 had a low birth weight rate twice that of married under 15 mothers.

In a 1976-78 study of infant mortality and morbidity, using a sample composed primarily of low birth weight babies from four regions of the U.S. (one region being Dallas County), teenage mothers 17 and younger and 18-19 year old multiparas (i.e., second-time mothers) were identified as high risk groups. Neonatal mortality rates (0-27 days), post-neonatal mortality rates (28 days to 11 months), and infant mortality rates (up to 1 year of age) were higher for the high risk groups than mothers 20 years and older. Non-white mothers had higher rates as compared to whites. For example, among mothers 17 and younger, the infant mortality rate for whites was 17.99 (per 1,000 live births) but 23.24 for nonwhites.

Table 1.9

Number and Percent of Live Births That are Low Birth Weight (Less Than 2500 Grams)

By Age of Mother and By Ethnicity

TEXAS, 1982

| Ethnicity | Age of Mother | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Under 15 | | 15 - 17 | | 18 - 19 | | 20 - 24 | | 25+ | | Unspecified | | Total | |
| | # | % | # | % | # | % | # | % | # | % | # | % | # | % |
| Anglo | 29 | 12.6 | 573 | 8.5 | 1,070 | 7.3 | 3,287 | 5.8 | 4,548 | 5.4 | 12 | 16.9 | 9,519 | 5.8 |
| Black | 72 | 17.3 | 576 | 13.8 | 784 | 13.9 | 1,784 | 12.0 | 1,677 | 11.2 | 8 | 20.5 | 4,901 | 12.2 |
| Hispanic | 44 | 10.0 | 571 | 8.0 | 775 | 7.2 | 1,857 | 6.1 | 2,343 | 5.8 | 8 | 12.5 | 5,598 | 6.3 |
| Other | 1 | 33.3 | 10 | 13.5 | 29 | 11.8 | 113 | 8.2 | 253 | 6.4 | 0 | 0.0 | 406 | 7.2 |
| Total | 146 | 13.4 | 1,730 | 9.5 | 2,658 | 8.5 | 7,041 | 6.8 | 8,821 | 6.1 | 28 | 15.8 | 20,424 | 6.9 |

Source: Texas Departemnt of Health, Bureau of Vital Statistics, Live Birth Statistical File, 1982

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section, March 1984

Table 1.10

Percent Births
Low Birth Weight, By Marital Status
of Mother, Texas 1982

| Mother's Marital Status | Age of Mother | | | |
|---|---|---|---|---|
| | Under 15 | 15 - 17 | 18 -19 | Under 20 |
| Married | 7.2 | 8.0 | 7.3 | 7.5 |
| Unmarried | 14.9 | 10.9 | 11.3 | 11.3 |

Source: Texas Department of Health, Bureau of Vital Statistics, Live Births Statistical File, 1982. This table excludes 1,279 cases (2.5%) out of a total of 50,585 births to teenagers) in which birth weight or prenatal care statu was not included.

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section, March 1984.

Note: * Births defined as low weight when the birth weight is less than or equal to 5.5 pounds (approximately 2500 grams).

This study also reveals that the offspring of teen mothers were more likely to suffer from illnesses resulting in hospitalization, injuries for which medical attention was sought, and prolonged illness. For instance, among high risk mothers, 15.3 percent of their offspring suffered from a prolonged illness, as compared to 9.48 percent of the offspring of mothers 20 and older.

In this particular study, it was determined that socioeconomic disadvantage appears to be associated with high risk (i.e., teenage mothers) groups.[13] However, it is important to note 71.2 percent of mothers 20 and older had private insurance which covered the costs of care. In comparison, Medicaid and "other" sources played a more significant role for the costs of the infants' of teenage mothers (see Tables 1.11, 1.12).[14]

## Reliance Upon Family Resources

The Select Committee's concern for family financial pressures related to a teenage pregnancy depends, of course, upon the extent of teen mothers' reliance upon family resources. Unmarried teen mothers (i.e., dependent minors) will, in all likelihood, be dependent upon parental resources for financial assistance as well as emotional support.

In a study by Rossa, Fitzgerald, and Carson of 67 mothers--17 of whom were teens--the living arrangements during the last trimester of pregnancy revealed that 35 percent of expectant teen mothers were living with parents, 18 percent were living alone, and 29 percent were living with a male partner. Those teens living with their parents tended to report higher family incomes than the other teen mothers. In comparison to older mothers in the sample (20-32 years old), 90 percent of the older mothers were living with the male partner; none were living with the parents.[15]

Table 1.11

Sociodemographic Characteristics of Family at One-Year of Age
By Maternal Age, Source of Payment for Infants' Medical Care,
Four Geographic Regions in the U.S., 1976 and 1978.

| | Young Mothers[a] at High Risk for Infant Loss | | | Young Mothers[b] at Low Risk for Infant Loss | | | Mothers ≥ 20 Years Old | | |
|---|---|---|---|---|---|---|---|---|---|
| | 1976 (444) | 1978 (459) | Total (903) | 1976 (164) | 1978 (180) | Total (344) | 1976 (2413) | 1978 (2628) | Total (5041) |
| Annual Family Income (percentile)[c] | | | | | | | | | |
| Lower Third | 60.5% | 54.3% | 57.6% | 49.4% | 56.7% | 53.2% | 21.2% | 16.2% | 18.6% |
| Middle/Upper Third | 39.5 | 45.7 | 42.4 | 50.6 | 43.3 | 46.8 | 78.7 | 83.8 | 81.4 |
| | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Source of Payment for Infants' Medical Care[d] | | | | | | | | | |
| Self | 23.1% | 20.0% | 21.6% | 24.5% | 20.2% | 22.4% | 14.5% | 15.8% | 15.2% |
| Private Insurance | 25.3 | 34.6 | 29.8 | 39.2 | 34.8 | 37.0 | 69.1 | 71.2 | 70.2 |
| Medicaid | 29.2 | 22.6 | 26.0 | 24.3 | 23.5 | 23.9 | 5.7 | 6.0 | 5.8 |
| Other | 22.3 | 22.9 | 22.6 | 12.1 | 21.5 | 16.7 | 10.8 | 7.0 | 8.9 |
| | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |

a) Mothers age 17 and younger and 18-19 year old multiparas (second or higher order births).
b) 18-19 year old primaparas (first order births).
c) Annual income in percentiles for given year, all ages combined, to adjust for inflation.
d) First year of medical care for infants.

Source:
Marie McCormick, Sam Shapiro, and Barbara Starfield, "High-Risk Young Mothers: Infant Mortality and Morbidity in Four Areas in the United States, 1973-1978," American Journal of Public Health, vol. 74, no. 1 (January 1984): 21.

Table 1.12

Sociodemographic Characteristics of Family at One-Year of Age By Maternal Age, Source of Payment for Infants' Medical Care, Four Geographic Regions in the U.S., 1976 and 1978, by Race

| | White | | | Non-White | | |
|---|---|---|---|---|---|---|
| | Young Mothers[a] at High Risk of Infant Loss (465) | Young Mothers[b] at Low Risk of Infant Loss (236) | Mothers ≥20yrs (4080) | Young Mothers at High Risk of Infant Loss (438) | Young Mothers at Low Risk of Infant Loss (108) | Mothers ≥20 yrs (960) |
| Annual Family[c] Income | | | | | | |
| Lower Third | 50.0 | 55.8 | 15.0 | 73.3 | 77.0 | 42.4 |
| Middle/Upper Third | 50.0 | 44.2 | 85.0 | 26.7 | 23.0 | 57.6 |
| Source of Payment for Infant's[d] Medical Care | | | | | | |
| Self | 27.0 | 24.4 | 15.4 | 11.2 | 17.2 | 13.5 |
| Private Ins. | 35.6 | 46.6 | 73.9 | 18.6 | 12.1 | 45.9 |
| Medicaid | 14.7 | 16.0 | 3.4 | 47.9 | 44.3 | 21.6 |
| Other | 22.8 | 13.0 | 7.3 | 22.3 | 26.4 | 19.9 |

a) Mothers age 17 and younger and 18-19 year old multiparas (second or higher order births).
b) 18-19 year old primaparas (first order births).
c) Annual income in percentailes for given year, all ages combined, to adjust for inflation.
d) First year of medical care for infants.

Source:
Marie McCormick, Sam Shapiro, and Barbara Starfield, "High-Risk Young Mothers: Infant Mortality and Morbidity in Four Areas in the United States, 1973-1978," American Journal of Public Health, vol. 74, no. 1 (January 1984): 22.

A Child Welfare League of America (1982) report on 12-15 year old mothers reveals that 88 percent of these young mothers were living with their parent(s) (one or both); 38 percent received financial support from their father's employment and 30 percent from their mother's employment.[16]

A 1980 study of unmarried mothers in New York City, develops four indicators of parental assistance: housing, child care, financial aid, and emotional support. This study reveals that a majority of unmarried teen mothers lived with their mothers (fathers rarely shared in the provision of housing). In addition, 25 percent of the teens who had not married three years after the births of their first children were living with their mothers.[17]

In the study, child care and emotional support from the mother were relied upon heavily. In regard to financial support, 85 percent of the teen mothers who had lived with their mothers reported receiving such aid. This compares to 36 percent among those who had not lived with their mother. Among never-married teen mothers, 65 percent said their mothers or fathers had helped them financially.

## Summary

Characteristics of the pregnant teenage population vary greatly on the basis of age, race/ethnicity, and socioeconomic factors. Although greater numbers of teens are becoming pregnant each year, there are actually fewer births due to an increase in abortions among teen women. Teens that decide to carry their pregnancy to term are most likely not married and are most often dependent on their families for emotional as well as financial support. Teen mothers are also at a higher risk of complications than are older women and experience a greater incidence of low birth weight babies, pre-mature deliveries, toxemia, and anemia.

Footnotes

[1] The Alan Guttmacher Institute, "Population aged 15-19, pregnancies to females aged 15-19 by outcome and birth, abortions and pregnancy rates by state, 1978." (Mimeographed table.)

[2] National Center for Health Statistics, Vital Statistics of the United States, annual volumes, as cited in Marjory E. Mecklenburg and Patricia G. Thompson, "The Adolescent Family Life Program as a Prevention Measure," Public Health Reports, vol. 98, no. 1 (January/February 1983): 22.

[3] U.S. Department of Commerce, Bureau of the Census. Provisional Projections of the Population of States, by Age and Sex: 1980 to 2000, by Signe I. Wetrogan, Current Population Reports, Population Estimates and Projections, Series P-25, no. 937 (August 1983), 8.

[4] Stanley Henshaw, et. al, Abortion 1977-1979: Need and Services in the U.S., Each State and Metropolitan Area, The Alan Guttmacher Institute (AGI), New York, 1981, Table II-3; AGI Survey and Center for Disease Control, Abortion Surveillance, Annual Summary, 1979-1980, Atlanta, 1983, as cited in The Alan Guttmacher Institute, Abortion Services, in the United States, Each State, and Metropolitan Area, 1979-1980, Stanley K. Henshaw, ed., (New York: The Alan Guttmacher Institute, 1983), 55.

[5] Melvin Zelnik and John F. Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979," Family Planning Perspectives, vol. 12, no. 5 (September/October 1980): 234.

[6] Ibid., 234.

[7] Kristin A. Moore and Martha R. Burt, Private Crisis, Public Cost, Policy Perspectives on Teenage Childbearing (Washington, D.C.: Urban Institute, 1982), 83-84.

[8] Stanley Henshaw and Kevin O'Reilly, "Characteristics of Abortion Patients in the United States, 1979 and 1980," Family Planning Perspectives, vol. 15, no. 1 (January/February 1983): 8.

[9] Ibid., 6.

[10] S. Henshaw, et. al., Abortion 1977-1979; The Alan Guttmacher Institute Survey and the Center for Disease Control, Abortion Surveillance, as cited in The Alan Guttmacher Institute, Abortion Services in the U.S. (Table 1), 55.

[11] The Alan Guttmacher Institute, Teenage Pregnancy, The Problem That Hasn't Gone Away, 29.

[12] Marie C. McCormick, et. al., "High-Risk Young Mothers: Infant Mortality and Morbidity in Four Areas in the United States, 1973-1978," American Journal of Public Health, vol. 74, no. 1 (January 1984): 19.

[13] In this study, teen mothers were asked the following questions about income level: "For the past year, which of these income classifications [i.e., lower third, middle third, upper third] represents your total combined household income before taxes for all sources, including wages, salaries, social security, welfare, help from relatives, other?" This question format relies upon the teen mother's knowledge of income, particularly parental support, and thus may be an imprecise indicator of income background. Nonetheless, it is valuable as a ballpark figure.

[14] Two possible reasons for the low level of private insurance coverage may be due to low income and/or the failure of particular private insurance policies to provide this type of coverage. However, it is impossible to determine to what extent the issue centers around dependent minor care given two factors. First, approximately 30-32 percent of the sample population is working; their health insurance policies may be responsible for some of private insurance's role. Second, the study does not reveal how many of the mothers are unmarried (and thus still classifiable as dependent minors).

[15] Mark W. Roosa, et. al., "Teenage and Older Mothers and Their Infants: A Descriptive Comparison," Adolescence, vol. XVII, no. 65 (Spring 1982): 6.

[16] Child Welfare League of America, "CWLA News Release," X-15, 1982. (Mimeograph.)

[17] Harriet B. Presser, "Sally's Corner: Coping With Unmarried Motherhood," Journal of Social Issues, vol. 36, no. 1 (1980): 116-117.

## CHAPTER 2

## PREGNANCY-RELATED SERVICES AND COSTS

The resolution of a teenage pregnancy (i.e., live birth, abortion, or miscarriage) involves medical procedures which not only have an impact upon the health of the teenage mother and infant but also potentially affect a number of parties, financially and otherwise: the pregnant teenager, the father, the teenage woman's parent(s), private insurance carriers, and the government via public assistance. It is uncertain how these parties interact in the payment of health care services for the pregnant teen. While it is beyond the scope of this study to gauge the full financial impact of a teenage pregnancy upon families, an examination of the utilization of services and costs involved will provide perspective on the burdens which accompany a teenage pregnancy.

The issue of contraception and averting a teenage pregnancy also merits consideration. This chapter will discuss the paths taken in resolving and/or averting pregnancies and the costs involved. Topics include the use of contraceptive services, abortion, live births, and the complications associated with live births (e.g., low birth weight). This chapter will also briefly discuss sources of payment for pregnancy-related services.

### Family Planning/Contraception

In examining the utilization of pregnancy-related services and the role that private insurance may play in providing those services, it is also important to discuss contraceptives and the issue of fertility control. Contraceptive use involves questions of medical and financial concerns when considered alongside the issues of resolving teen pregnancy. Averting a teen pregnancy also entails the aversion of the high risk and high costs often

associated with maternity among teenage women. In addition, the use of contraceptives by adolescents involves the parent/child decision-making process (i.e., parental approval, teenage attitudes about using contraceptives with or without parental knowledge and approval), the outcome of which will effect the utilization of private insurance as a source of payment for contraceptives. The parent/child relationship also needs to be considered if insurance coverage for dependent minor pregnancy-related expenses is contemplated as a mandated benefit.

Parental Notification: Private insurance coverage for contraceptives for teens is a problematic issue given attitudes about teenagers utilizing contraceptives and given teenagers' willingness/unwillingness to tell their parents they are using contraceptives. In addition, family planning clinic and physician policies regarding parental notification add to the confusion. Realistically, the utilization of private insurance would require that parents find out through claims receipts. In a 1980 Alan Guttmacher Institute national survey, 31.4 percent of teens reported the reason for delaying, on the average of nine months, seeking contraceptive assistance as "fear that the family would find out." The most common reason given (by 38.1 percent) was a failure "to get around to it."[1] Other major reasons given included "waiting for closer relationship with partner," "thought birth control dangerous," and "afraid of examination."

With regard to notification and consent practices, one out of five family planning service providers reported requiring parental notification for patients under 15. Ten percent required notification for patients 16-17 years of age. Hospitals were most likely to require parental consent or notification for family planning services. Nineteen percent had such a requirement for 16-17 year old patients. Health departments were less likely to

require notification/consent (10 percent for 16-17 year old patients; 18 percent for patients under 15). Planned Parenthood agencies had the least restrictive consent requirements: three percent for under 15 patients and one percent for 16-17 year olds.[2]

A study of family planning patients younger than 18 reports that approximately half of the teens told their parents about their clinic visits. In addition, the younger the teen, the more likely the parents knew about the family planning visit. However, 54 percent of teens younger than 18 utilizing services reported that their parents didn't know and that they wouldn't come if they had to know.[3]

Utilization of Contraceptives: According to a 1980 study among teen women who ever used a contraceptive method, the most commonly-used prescription methods were birth control pills (40.6 percent), the diaphragm (3.5 percent), and the intrauterine device (IUD) (3.5 percent).[4] The popularity of the pill is evidenced by a 1976 study, in which 31 percent of teen women who first visited a family planning clinic were using the pill. After enrollment in the clinic program, 78 percent were pill users. The proportion of non-contraceptors dropped dramatically among clinic users--from 50 percent before clinic participation, and down to six percent after enrollment. A 1976 study by Zelnik and Kantner reveals that 45 percent of all first oral contraceptive prescriptions for sexually active unwed teenagers were obtained from family planning clinics; 54.1 percent obtained the first oral prescription from a private physician.[5]

Cost of Contraceptives: In reference to costs of contraceptive methods, prescription methods (i.e., those that entail physician costs) are the most expensive. The pill, IUD, and diaphragm are the most expensive and most effective methods. They require a physician's prescription in addition to the cost of supplies.

The Alan Guttmacher Institute (AGI) has calculated the first year costs for various contraceptive methods. Of those methods which require a prescription, the AGI developed a standard of two visits involved in establishing contraceptive usage: the initial medical history (involving a physical examination and laboratory tests) and a follow-up visit.[6] In 1981-82, the cost for an initial visit ($41) and follow-up ($24) totaled $65 (see Table 2.1). Additional supply costs are also involved, with the pill's prescription costs of approximately $107 yearly (i.e., $8.26 per cycle X 13 cycles = $107); the diaphragm at $95 per year (the device plus spermicidal jelly); and the IUD at $66 a year (for the device plus insertion). Table 2.1 shows that the pill is the most expensive prescription method at $172 per year, followed by the diaphragm ($160) and the IUD ($131).

In Texas, of these three prescription-methods, insurance coverage of oral contraceptives must be provided in policies which provide coverage of all other prescription drugs. Coverage for other forms of contraception is generally not provided. Further discussion of contraceptive coverage is provided in Chapter 3.

Table 2.1

Estimated First-Year Costs of
Various Contraceptive Methods,
By Type of Expense

| Method | Total | Medical | Supplies |
|---|---|---|---|
| Prescription | | | |
| Pill | $ 172 | $ 65 | $ 107 |
| Diaphragm | 160 | 65 | 95 |
| IUD | 131 | 65 | 66 |

Source: Aida Torres and Jacqueline Forrest, "The Costs of Contraception", Family Planning Perspectives, vol. 15, no. 2 (March/April 1983): 71.

## Abortion

In this study of pregnancy-related services, abortion is a relevant issue on two grounds. The Select Committee and HCR 84 were concerned with an optimal pregnancy outcome; the possibility of complications of pregnancy may require that the pregnancy be terminated by a therapeutic abortion. Furthermore, concern for the health and welfare of the teen mother and the infant and the concern for the financial burden of a teen pregnancy upon parental resources necessitates that all pregnancy resolution options be considered. This is particularly important given that the legalization and increased use of abortion have had an impact on birth rates and the relationship between birth rates and sexual activity.

Abortion Facilities: In 1980, it is estimated that 102,000 abortions were performed in Texas. [Note: These are estimates only. Abortion is not reported in Texas.] The Alan Guttmacher Institute estimates that 90 percent were performed in nonhospital clinics, 4 percent in physicians' offices, and two percent and three percent, respectively, in public and private hospitals.[7] There were 126 abortion providers in Texas in 1980--the majority of which were nonhospital clinics (43 percent) and physicians' offices (33 percent).

Abortion Procedures: According to the Alan Guttmacher Institute, the most commonly used abortion procedure is instrumental evacuation, accounting for 95.6 percent of abortions in 1980.[8] Control Abortion Surveillance data (1980) show that, nationally, 78.3 percent of all abortions occurred prior to or by the 10th week of gestation. An additional 13 percent were performed in the 11th and 12th weeks. Thus, approximately nine out of ten abortions were performed in the first trimester; 4.7 percent were performed in weeks 13-15.

However, a 1978 study by Tietze of the Population Council estimates that teen women delay their abortions when compared with older women.[9] This is an important distinction because abortions which occur later in gestation are riskier for the mother. Among 15-19 year olds, 41 percent obtained abortions by or at the eighth week of gestation; 87 percent obtained first trimester abortions. Among women under 15, 34 percent received abortions in the eighth week or earlier; 77 percent received first trimester abortions.

In comparison, 92 percent of abortions among women 20-24 were first trimester; 51 percent were by the eighth week or earlier. Among women under 15, only 14 percent of their abortions were in the sixteenth week or later. This is twice the rate for women 15-19 (7 percent). Only 4 percent of the abortions among women 20-24 were performed in the sixteenth week or later.

Cost and Payment of Abortion: A 1979-1980 study was conducted of unmarried abortion patients under 18 who utilized services of free-standing abortion clinics. These women were surveyed on a number of issues, including payment for the abortion. Results revealed that two-fifths of the abortions obtained by girls 15 and younger were paid for entirely by the parents, one-fifth by partners, and one-fourth by Medicaid. In one-tenth of the cases, the cost is shared by the patient and her parents or partner (see Table 2.2).[10] Among 16 year old teens, 26 percent of the cost of an abortion was covered by parents; among 17 year olds, 18 percent was paid for by the parents. The older the pregnant teen, the more important becomes the male partner, the patient, and all involved parties in the sharing of costs; Medicaid becomes a less significant source of payment.

Three-fourths of the parents of patients 15 and under knew of the abortion; approximately half of the parents of 16 and 17 year old patients knew of the abortion. Almost half of the patients 15 and under voluntarily told their parents about the abortion. Among 16 and 17 year olds, 37 percent and 35 percent, respectively, voluntarily told their parents. Twenty-four percent of the abortions performed upon women 15 and under were suggested by the parents, as compared to 11 percent and 8 percent, respectively, for 16 and 17 year old patients.[11]

As Table 2.3 reveals, the cost of an abortion procedure in a non-hospital clinic (wherein 90 percent of abortions are performed) varies according to the type of anesthesia used (local versus general) and gestational age of the pregnancy. The average charge of $190 in 1980 for a local tenth week abortion is 15 percent greater than for a comparable 1976 procedure at $165.

Table 2.2

Payment Distribution for Teenage* Abortions, 1979-1980

| | Age | | |
|---|---|---|---|
| | 15 and under | 16 | 17 |
| Male Partner | 20% | 34% | 33% |
| Parents | 41 | 26 | 18 |
| Patient | 4 | 6 | 11 |
| All Parties | 11 | 16 | 22 |
| Medicaid | 24 | 18 | 16 |
| Total | 100% | 100% | 100% |

* unmarried teenage women

Source: Aida Torres, et. al., "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," Family Planning Perspectives, vol. 12, no.6 (November/December 1980):289.

This cost increase, however, is below the rise in the consumer price index over this same time period. The additional cost of general anesthesia averages $45 for a tenth week abortion but varies by the type facility in which the abortion was performed: $23 in physicians' offices, $49 in clinics, $24 in unlicensed clinics, and $48 in licensed clinics (see Table 2.3).[12]

Use of local or general anesthesia varies. A survey of National Abortion Federation (NAF) facilities--primarily of non-hospital clinics--reveals that 58 percent always used local anesthesia and never general anesthesia. Twenty-one percent give the patient the option of the type anesthetic used. The six hospital-based clinics in the NAF survey preferred to use general anesthesia; among non-hospital clinics, 88 percent always or usually used local anesthesia.[13] Of second trimester abortions, 71 percent of abortion providers performing this procedure reported always using local anesthesia.

The cost of a hospital abortion is considerably higher than clinic abortions (see Table 2.3). A 1982 Alan Guttmacher Institute survey found the average cost to be $735, including physician's fees, with a range from $275 to $1,300. A first trimester inpatient abortion (45 percent of hospital abortion providers offered inpatient services only) reported an average cost of $860 and ranged from $150 to $1,600. Physician's fees for a first trimester hospital procedure averaged $330. The average cost of a saline instillation or prostaglandin abortion (approximately 4.3 percent of abortions, usually reserved for second trimester abortions) was $940.

Table 2.3

Non-Hospital Clinic Charges for Abortions, by Type of Anesthesia and Gestational Age
(Weeks After Last Menstrual Period [LMP])

| Type Anesthesia and Weeks Since LMP | Mean Charge | Standard Deviation | Low | High |
|---|---|---|---|---|
| Local | | | | |
| 10 weeks | $190 | $33 | $120 | $300 |
| 12 | 193 | 38 | 120 | 325 |
| 14 | 263 | 63 | 150 | 450 |
| 16 | 358 | 75 | 175 | 600 |
| General | | | | |
| 10 weeks | $230 | $44 | $140 | $350 |
| 12 | 234 | 48 | 140 | 350 |
| 14 | 308 | 72 | 205 | 500 |
| 16 | 364 | 104 | 210 | 600 |

Hospital Charges for Abortions

| | Average Charge | Range |
|---|---|---|
| Hospital | $735 | $275 - $1,300 |
| First trimester inpatient abortion* | 860 | $150 - $1,600 (includes $330 physician's fee) |
| Hospital saline instillation or prostaglandin (usually second trimester abortion) | 940 | |

* 45% of hospital abortion providers offer in-hospital only

source: Stanley K. Henshaw, The Alan Guttmacher Institute/National Abortion Federation Abortion Survey, 1980, "Freestanding Abortion Clinics: Services, Structures, Fees," Family Planning Perspectives, vol. 14, no. 5 (September/October 1982): 254-255.

## Live Births - Overview

In 1982, there were 50,585 live births among Texas women under 20 years of age. According to the 1980 National Hospital Discharge Survey (NHDS), delivery was the leading diagnostic condition for adolescent females, accounting for 32 percent of discharges. Abortion and complications mainly related to pregnancy each accounted for 5 percent of discharges. By specific age, the NHDS reveals obstetrical conditions as a percentage of discharges as shown in Table 2.4. Obstetrical conditions become more significant reasons for hospital stays among older teen women.

In 1980, the average length of stay (ALOS) in a hospital for a teenage woman's delivery was 3.7 days,[14] as compared to the overall average of 5 days for female non-obstetrical conditions and the average of 5.4 days for adolescent male stays.[15] The average length of stay for deliveries among women of all ages was 3.8 days, which is not a statistically significant difference than the ALOS for teen mothers (see Table 2.5).[16]

Normal and Cesarean Births: Women with normal deliveries had an average length of stay of 3.0 days, as compared to 4.5 days for a complicated delivery. According to the 1980 National Hospital Discharge Survey (NHDS), 48.9 percent of all deliveries were classified as normal, with the remainder considered complicated. For women 10-19 years old, 49.9 percent were normal. Usage of the term "complicated" is all-encompassing, however, including conditions routine in nature as well as more difficult procedures (e.g., forceps or vacuum extraction delivery, obstetrical trauma, perineal laceration, laceration of the cervix, breech, cesarean).

Table 2.4

Female* Adolescent Discharges from Short-Stay Non-Federal Hospitals, Number, Percent Obstetrical, Percent Distribution, By Age of Patient (12-19), United States, 1980

| Age | Number Obstetrical | Total Female Discharges | Percent Obstetrical | Percent Distribution |
|---|---|---|---|---|
| 12 | 1 | 64 | 1.5% | .13 |
| 13 | 4 | 87 | 4.6 | .52 |
| 14 | 18 | 113 | 15.9 | 2.3 |
| 15 | 40 | 170 | 23.5 | 5.2 |
| 16 | 83 | 240 | 34.6 | 10.8 |
| 17 | 149 | 316 | 47.2 | 19.4 |
| 18 | 206 | 386 | 53.4 | 26.8 |
| 19 | 267 | 452 | 59.0 | 34.7 |
| total | 770 | 1,829 | 42.0 | 100.0 |

* females in sample: currently married 22.6
never married 70.9
other & not stated 6.5

Source: National Center for Health Statistics, National Hospital Discharge Survey, "The Utilization of Short-Stay Hospitals by Adolescents: United States, 1980," by Edmund J. Graves, Advance Data, no. 93 (September 14, 1983) (Table 1), 2.

Table 2.5

Average Length of Stay (ALOS) in Hospital
(Short-Stay Non-Federal Hospitals),
U.S., 1980-1981

| Reason for Hospital Stay | ALOS (days) | |
|---|---|---|
| Delivery (all females) | 3.8 | (b) |
| Delivery (adolescent females) | 3.7 | (a) |
| - normal | 3.0 | (b) |
| - complicated | 4.5 | (b) |
| - cesarean | 6.2 | (c) |
| Non-obstetrical (adolescent females) | 5.0 | (a) |
| Adolescent males | 5.4 | (a) |
| Newborn infants (average) | 3.9 | (d) |
| - "well" infant | 3.2 | (d) |
| - "sick" infant | 5.9 | (d) |

Sources:
(a) NCHS, "Utilization of Short-Stay Hospitals by Adolescents," Advance Data, Sept., 1983:2.
(b) NCHS, "Deliveries in Short-Stay Hospitals," Advance Data, Oct. 8, 1982:1.
(c) Paul Placek, et.al., "Cesarean Section Delivery Rates," American Journal of Public Health, August 1983:861.
(d) NCHS, "Utilization of Short-Stay Hospitals, 1981." Vital and Health Statistics, Sept. 1983, 15.

The 1981 NHDS reveals that, in 1981, 17.9 percent of all births were cesarean; only 13.2 percent of teenage births were cesarean.[17] Among women 20-24 years old, 16 percent of their deliveries were cesarean. The average length of stay for a cesarean section was 6.2 days (see Table 2.5).[18] The frequency with which cesarean sections are performed has shown an historical increase. In 1970, only 3.1 percent of teen deliveries were cesarean section; by 1981, 13.2 percent were cesarean. A similar pattern holds for 20-24 year old women; from 1970 to 1981, the rate increased from 4.9 percent to 16 percent.[19]

The Cost of Delivery: The Health Insurance Association of America (HIAA) developed 1982 cost estimates for normal delivery (i.e., no complications) and cesareandelivery (see Table 2.6). Costs vary by urban/ rural and region of the United States. The average total cost in 1982 for a normal delivery in the Southern region of the U.S. (which includes Texas) was $1,912.30; a cesarean delivery cost $2,986.30. These charges included professional services (i.e., attending physician) which amounted to $621.10 for normal and $804.60 for cesarean deliveries (see Table 2.7). Excluded are the anesthesiologist's professional fee ($150 national average) and pediatrician's newborn care ($64 national average). Adding these costs would bring the total cost to $2,126.30 for normal delivery and $3,280.30 for cesarean delivery.

The cost of a hospital stay for a normal delivery (excluding professional services) include: room and board (3.1 days X $119.00 per day = $368.90); nursery (3.1 days X $81.20 = $251.70); labor room/delivery room ($294.10); and a number of other charges (e.g., anesthesia, central supplies, pharmacy) (see Table 2.8). Hospital stay costs for cesarean delivery include: room and board (5.6 days X $119.00 = $666.30); nursery (5.6 days X $81.20 = $454.70); labor room/delivery room ($294.10); central supplies ($232.50); pharmacy ($208.10); and other assorted charges.

Table 2.6

Average Cost of Professional Services in Urban and Rural Areas of the South, 1982

| | URBAN | RURAL | TOTAL |
|---|---|---|---|
| Attending Physician: | | | |
| Usual Delivery | $598.60 | $547.20 | $576.50 |
| Cesarean Delivery | $785.00 | $726.90 | $760.00** |
| Circumcision | $ 46.80 | $ 41.80 | $ 44.60 |
| Total: | | | |
| Usual Delivery | $645.40 | $589.00 | $621.10 |
| Cesarean Delivery | $831.80 | $768.70 | $804.60 |

NOTE: Excludes anesthesiologist professional fee, which averages $150 nationally for a usual delivery, and pediatrician's newborn care, which averages $64 nationally.

Source: Health Insurance Association of America, "The Cost of Having a Baby," Report of a Survey by the Public Relations Division of the HIAA, 1983, Table 7.

Table 2.7

Total Medical Costs of Having a Baby

| | Usual Delivery | | |
|---|---|---|---|
| | Delivery Room | Birthing Room | Cesarean |
| Northeast | | | |
| Urban | $2,312.50 | $2,199.20 | $3,708.60 |
| Rural | 2,127.10 | NA | 3,328.50 |
| Total | 2,285.50 | NA | 3,647.50 |
| South | | | |
| Urban | 1,960.20 | 1,930.20 | 3,044.40 |
| Rural | 1,810.10 | 1,782.70 | 2,916.50 |
| Total | 1,912.30 | 1,889.60 | 2,986.30 |
| North Central | | | |
| Urban | 2,287.00 | 2,137.10 | 3,620.40 |
| Rural | 1,833.80 | 1,726.80 | 3,064.90 |
| Total | 2,128.40 | 2,003.80 | 3,427.20 |
| West | | | |
| Urban | 2,283.50 | 2,321.40 | 3,762.20 |
| Rural | 1,615.80 | 1,503.30 | 2,860.10 |
| Total | 2,148.50 | 2,170.50 | 3,584.80 |
| U.S. | | | |
| Urban | 2,209.10 | 2,175.90 | 3,511.80 |
| Rural | 1,819.70 | 1,734.90 | 3,001.70 |
| Total | 2,092.70 | 2,062.50 | 3,340.30 |

NA = Not Available

NOTE: Excludes anesthesiologist's professional fee, which averages $150 nationally for a usual delivery and pediatrician's newborn care, which averages $64 nationally.

Source: Health Insurance Association of America, "The Cost of Having a Baby," Report of a Survey by the HIAA, 1983, Table 11.

Table 2.8

Average Cost of Maternity Hospital Stay in Urban & Rural Areas of the South Region of the U.S., 1982

| | URBAN | RURAL | TOTAL |
|---|---|---|---|
| Usual Delivery | | | |
| Room and Board (urban - 3.1 days at $123.80/day; rural - 2.9 days at $112.60; total - 3.1 days at $119.00) | $ 383.80 | $ 326.50 | $ 368.90 |
| Nursery (urban - 3.1 days at $83.80/day; rural - 2.9 days at $77.70; total - 3.1 days at $81.20) | 259.80 | 225.30 | 251.70 |
| Labor Room | 103.60 | 103.50 | 103.60 |
| Delivery Room | 214.70 | 157.30 | 190.50 |
| Birthing Room (alternative to labor and delivery rooms) | 288.30 | 233.40 | 271.40 |
| Circumcision Set-up | 20.30 | 18.60 | 19.60 |
| Anesthesia (equipment and supplies)* | 61.70 | 67.60 | 64.20 |
| Central Supplies | 110.00 | 139.80 | 122.70 |
| Pharmacy (mother and baby) | 71.80 | 77.90 | 74.40 |
| Laboratory (mother and baby) | 89.10 | 104.60 | 95.60 |
| Total - with Labor and Delivery Rooms | $1,314.80 | $1,221.10 | $1,291.20 |
| Total - with Birthing Room | $1,284.80 | $1,193.70 | $1,268.50 |
| Cesarean Delivery | | | |
| Room and board (urban - 5.7 days at $123.80/day; rural - 5.5 days at $112.60; total - 5.6 days at $119.00) | $ 705.70 | $ 619.30 | $ 666.30 |
| Nursery (urban - 5.7 days at $83.80/day; rural - 5.5 days at $77.70; total - 5.6 days at $81.20) | 477.70 | 427.40 | 454.70 |
| Labor Room | 103.60 | 103.50 | 103.60 |
| Delivery Room | 214.70 | 157.30 | 190.50 |
| Circumcision Set-up | 20.30 | 18.60 | 19.60 |
| Anesthesia (equipment and supplies)* | 129.00 | 129.30 | 129.10 |
| Central Supplies | 187.10 | 292.50 | 232.50 |
| Pharmacy (mother and baby) | 197.70 | 221.80 | 208.10 |
| Laboratory (mother and baby) | 176.80 | 178.10 | 177.30 |
| Total | $2,212.60 | $2,147.80 | $2,181.70 |

* A few hospitals quoted fees that include the professional services of a staff anesthesiologist, which measurabley raises the average.

Source: Health Insurance Association of America, "The Cost of Having a Baby," Report of a Survey by the HIAA, 1983, Table 2.

## Complications of Pregnancy

The complications associated with teenage pregnancies and how they relate to the utilization and cost of care have a direct bearing upon family resources. Teenage pregnancies are distinguishable from pregnancies to older women in that maternal and infant mortality and morbidity are higher (see Chapter 1). These complications are attributable to poor teen nutrition, physical immaturity, and inadequate health care of teen mothers and their children.

Prenatal Care: Various studies indicate that prenatal care is an important factor in the reduction of complications of pregnancy--particularly in reducing the incidence of low birth weight babies, which is highly associated with pregnancy complications. Most physicians charge a global fee for delivery, the charge for which includes prenatal care. Thus, the estimates developed by the Health Insurance Association of America for the cost of delivery include prenatal care costs (see Table 2.7). The average cost of prenatal care only, in 1982 dollars, ranged from $220 to $250.[20] The American College of Obstetricians & Gynecologists (ACOG) definition of prenatal care is as follows:

> "Prenatal care may be defined as a planned program of medical evaluation and management, as well as observation and education of the pregnant woman directed toward making pregnancy, labor, delivery, and the interconceptional period a safe and satisfying family experience....ACOG recommends that prenatal care begin during the first trimester and include a comprehensive medical history, a physical examination, and a series of laboratory tests....According to ACOG, the normal patient should generally be seen at least every four weeks for the first 28 weeks of pregnancy, every two weeks until the 36th week, and weekly thereafter. In addition to the physical and laboratory tests conducted to assess

> any abnormalities which may require more intensive screening or treatment, visits should include plans for labor, delivery, neonatal care, and family planning."21

Prenatal Care and the Reduction of Low Birth Weight: It appears that the receipt of prenatal care has an effect on reducing the incidence of risk to mother and child. Given that 70 percent of perinatal (i.e., from 20 weeks of gestation up to 28 days of life) deaths are low birth weight babies, the most visible means of improving newborn infant health is to reduce the incidence of low birth weight babies.[22] One study shows that risks associated with age and socioeconomic status of mothers will be reduced to levels equivalent to the 20-24 year old age group, given adequate prenatal care.[23] Tables 2.9 and 2.10 crosstabulate the receipt of prenatal care with the incidence of low birth weight babies. As Table 2.9 shows, teen mothers and mothers 20 and older who received no prenatal care suffered a higher rate of low birth weight babies. Among married teen mothers, the incidence of low birth weight was 12.8 percent of those without prenatal care and 7.2 percent for those with prenatal care. Unmarried mothers showed an additional degree of risk as compared to married mothers; the low birth weight rate was 22.5 percent for unmarried teen mothers receiving no prenatal care.

Prenatal care is associated with an improvement in the outcome of the pregnancy given that poor maternal nutrition and poor health practices can be avoided. In 1982, approximately 54 percent of Texas teen mothers failed to receive any prenatal care until after the critical first trimester (see Table 2.11); 28.9 percent of mothers 20 and older failed to receive first trimester care. Furthermore, the younger the teen mother, the less likely she was to receive prenatal care in the first trimester. Only 29.9 percent of mothers under 15 received first trimester care; in contrast, 42.1 percent of 17 year old mothers received first trimester prenatal care.

Table 2.9

Cross Tabulation of Receipt of Prenatal Care by Birthweight
Texas 1982

| Mother's Marital Status | Prenatal Care Status | Age of Mother: All Women Low Weight* Births | All Women Total Births | All Women % Low Weight | Teens Only (20years) Low Weight* Births | Teens Only (20years) Total Births | Teens Only (20years) % Low Weight | Adults Only(20+ years) Low Weight* Births | Adults Only(20+ years) Total Births | Adults Only(20+ years) % Low Weight |
|---|---|---|---|---|---|---|---|---|---|---|
| Married | Received Prenatal Care | 14,363 | 245,306 | 5.9 | 2,230 | 30,842 | 7.2 | 12,133 | 214,464 | 5.7 |
| | No Prenatal Care | 749 | 6,234 | 12.0 | 186 | 1,452 | 12.8 | 563 | 4,782 | 11.8 |
| | Total | 15,112 | 251,540 | 6.0 | 2,416 | 32,294 | 7.5 | 12,696 | 219,246 | 5.8 |
| Unmarried | Received Prenatal Care | 3,854 | 36,847 | 10.5 | 1,588 | 15,538 | 10.2 | 2,266 | 21,309 | 10.6 |
| | No Prenatal Care | 687 | 3,392 | 20.3 | 330 | 1,468 | 22.5 | 357 | 1,924 | 18.6 |
| | Total | 4,541 | 40,239 | 11.3 | 1,918 | 17,006 | 11.3 | 2,623 | 23,233 | 11.3 |

Source: Live Birth Statistical File, 1982, Bureau of Vital Statistics, Texas Department of Health. This table excludes 5,904 cases (2.0% out of a total of 297,683 births) in which mother's age, birth weight, or prenatal care status was not indicated.

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section, March 1984.

Notes: * Births are defined as low-weight when the birth weight is less than or equal to 5.5 pounds (approximately 2500 grams).

Table 2.10

Cross Tabulation of Receipt of Prenatal Care by Birthweight, teen women, Texas, 1982

| Mother's Marital Status | Prenatal Care Status | Age of Mother: 14 Years and Younger — Low Weight* Births | Total Births | % Low Weight | 15 to 17 Years — Low Weight* Births | Total Births | % Low Weight | 18 to 19 Years — Low Weight* Births | Total Births | % Low Weight |
|---|---|---|---|---|---|---|---|---|---|---|
| Married | Received Prenatal Care | 17 | 241 | 7.1 | 715 | 9,288 | 7.7 | 1,498 | 21,313 | 7.0 |
| | No Prenatal Care | 2 | 23 | 8.7 | 68 | 483 | 14.1 | 116 | 946 | 12.3 |
| | Total | 19 | 264 | 7.2 | 783 | 9,771 | 8.0 | 1,614 | 22,259 | 7.3 |
| Unmarried | Received Prenatal Care | 91 | 703 | 12.9 | 696 | 7,197 | 9.7 | 801 | 7,644 | 10.6 |
| | No Prenatal Care | 26 | 82 | 31.7 | 161 | 650 | 24.8 | 143 | 736 | 19.4 |
| | Total | 117 | 785 | 14.9 | 857 | 7,847 | 10.9 | 944 | 8,380 | 11.3 |

Source: Live Birth Statistical File, 1982, Bureau of Vital Statistics, Texas Department of Health. This table excludes 1,279 cases (2.5% out of a total of 50,585 births to teenagers) in which birth weight or prenatal care status was not included.

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section, March 1984.



Notes: * Births defined as low weight when the birth weight is less than or equal to 5.5 pounds (approximately 2500 grams).

Table 2.11

Live Births by Trimester Prenatal Care was Initiated by Age of Mother
TEXAS, 1982

| Age of Mother | Trimester Prenatal Care Initiated | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | None | | First | | Second | | Third | | Unspecified | | Total | |
| | # | % | # | % | # | % | # | % | # | % | # | % |
| 15 | 105 | 9.7 | 325 | 29.9 | 454 | 41.7 | 165 | 15.2 | 39 | 3.6 | 1,088 | 100.0 |
| 15 | 204 | 7.7 | 942 | 35.6 | 1,046 | 39.5 | 372 | 14.0 | 85 | 3.2 | 2,649 | 100.0 |
| 16 | 388 | 6.8 | 2,235 | 38.9 | 2,246 | 39.1 | 707 | 12.3 | 168 | 2.9 | 5,744 | 100.0 |
| 17 | 546 | 5.6 | 4,101 | 42.1 | 3,723 | 38.2 | 1,119 | 11.5 | 247 | 2.5 | 9,736 | 100.0 |
| 18 | 839 | 6.1 | 6,500 | 47.0 | 4,683 | 33.9 | 1,499 | 10.8 | 308 | 2.2 | 13,829 | 100.0 |
| 19 | 846 | 4.8 | 9,092 | 51.8 | 5,459 | 31.1 | 1,737 | 9.9 | 405 | 2.3 | 17,539 | 100.0 |
| Total 20 | 2,928 | 5.8 | 23,195 | 45.9 | 17,611 | 34.8 | 5,599 | 11.1 | 1,252 | 2.5 | 50,585 | 100.0 |
| 20+ | 6,719 | 2.7 | 175,580 | 71.1 | 46,511 | 18.8 | 13,763 | 5.6 | 4,348 | 1.8 | 246,921 | 100.0 |
| Unspecified | 17 | 9.6 | 86 | 48.6 | 48 | 27.1 | 12 | 6.8 | 14 | 7.9 | 177 | 100.0 |
| Total All Ages | 9,664 | 3.2 | 198,861 | 66.8 | 64,170 | 21.6 | 19,374 | 6.5 | 5,614 | 1.9 | 297,683 | 100.0 |

Source: Texas Department of Health, Bureau of Vital Statistics, Live Birth Statistical File, 1982

Prepared by: Texas Department of Health, Bureau of Maternal and Child Health, Data Analysis and Statistical Section, March 1984

Teen mothers were also more likely to not receive any prenatal care throughout the entire pregnancy. Among all teen mothers, 5.8 percent received no prenatal care, while only 2.7 percent of mothers 20 and older failed to receive care. Younger teen mothers were even more unlikely to receive care. Similar trends held for racial/ethnic distinctions, wherein black and Hispanic mothers were more likely to receive no care at all (Table 2.12).

Unmarried women of all ages were also less likely to receive prenatal care. Among teens, unmarried mothers were twice as likely to not receive prenatal care (Table 2.13). Among mothers under 15, the failure rate was less distinct by marital status; married and unmarried women of this age had a high rate of no prenatal care.

Regardless of racial/ethnic status, unmarried teen mothers were far more likely not to receive prenatal care, relative to their married counterparts (Table 2.12). Among 18-19 year olds, 2.5 percent of white married mothers received no care; however, 7.3 percent of white unmarried women of this age received no care.

Some debate exists as to the reliability of information on the receipt of prenatal care. Women are questioned about the receipt of prenatalcare at the time of delivery. There is some indication that mothers--particularly teenage mothers--may inaccurately report the receipt of prenatal care. For example, the mother may mistakingly report her first pregnancy test as a prenatal visit. Embarrassment as to failure to obtain prenatal care may also entail some overreporting.

Table 2.12

Mothers Who Did Not Receive Prenatal Care
By Age, Marital Status, and Ethnicity
Texas, 1982

| Ethnicity/ Marital Status | < 15 | | 15 - 17 | | 18 - 19 | | 20 - 24 | | 25+ | |
|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % |
| Anglo | 18 | 7.8 | 284 | 4.2 | 495 | 3.4 | 1,150 | 2.0 | 768 | 0.9 |
| Black | 31 | 7.5 | 282 | 6.7 | 330 | 5.9 | 592 | 4.0 | 369 | 2.5 |
| Hispanic | 55 | 12.5 | 567 | 7.9 | 843 | 7.8 | 1,898 | 6.3 | 1,809 | 4.5 |
| Other | 1 | 33.3 | 5 | 6.8 | 17 | 6.9 | 57 | 4.1 | 76 | 1.9 |
| Total | 105 | 9.7 | 1,138 | 6.3 | 1,685 | 5.4 | 3,697 | 3.6 | 3,022 | 2.1 |
| Married | | | | | | | | | | |
| Anglo | 4 | 6.3 | 134 | 3.0 | 307 | 2.5 | 831 | 1.6 | 615 | 0.7 |
| Black | 1 | 9.1 | 24 | 4.6 | 69 | 3.9 | 210 | 2.5 | 177 | 1.6 |
| Hispanic | 18 | 9.1 | 323 | 6.5 | 561 | 6.5 | 1,380 | 5.2 | 1,457 | 3.9 |
| Other | 0 | 0.0 | 3 | 5.7 | 12 | 5.7 | 52 | 3.9 | 72 | 1.9 |
| Total | 23 | 8.4 | 484 | 4.8 | 949 | 4.2 | 2,473 | 2.8 | 2,321 | 1.7 |
| Single | | | | | | | | | | |
| Anglo | 14 | 8.3 | 150 | 6.6 | 188 | 7.3 | 319 | 7.7 | 153 | 6.3 |
| Black | 30 | 7.4 | 258 | 7.0 | 261 | 6.7 | 382 | 6.0 | 192 | 5.2 |
| Hispanic | 37 | 15.4 | 244 | 11.4 | 282 | 13.3 | 518 | 13.5 | 352 | 11.0 |
| Other | 1 | 33.3 | 2 | 9.5 | 5 | 15.2 | 5 | 7.8 | 4 | 5.1 |
| Total | 82 | 10.1 | 654 | 8.1 | 736 | 8.6 | 1,224 | 8.5 | 701 | 7.5 |

Table 2.13

Mothers Who Did Not Receive Prenatal Care
By Age and Marital Status
Texas, 1982

| Marital Status | All Women | | Teens | | Adults | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| Married | 6,259 | 2.4 | 1,456 | 4.4 | 4,794 | 2.1 |
| Single | 3,405 | 8.2 | 1,472 | 8.4 | 1,925 | 8.1 |
| Total | 9,664 | 3.2 | 2,928 | 5.8 | 6,719 | 2.7 |

Teenage Mothers

| Marital Status | Under 15 | | 15 - 17 | | 18 - 19 | |
|---|---|---|---|---|---|---|
| | # | % | # | % | # | % |
| Married | 23 | 8.4 | 484 | 4.8 | 949 | 4.2 |
| Single | 82 | 10.1 | 654 | 8.1 | 736 | 8.6 |
| Total | 105 | 9.7 | 1,138 | 6.3 | 1,685 | 5.4 |

Source: Live Birth Statistical File, 1982
Bureau of Vital Statistics
Texas Department of Health

Prepared by: Maternal and Child Health
Texas Department of Health

## Newborns

The 1981 NHDS finds that approximately three-fourths of all newborn infants were discharged from the hospital as "well" (i.e., no illness or risk-related diagnosis).[24] The overall average length of stay (ALOS) for all infants was 3.9 days (see Table 2.8). (The cost for "well" newborn hospital stays is included in Table 2.9.) The ALOS for "well" infants was 3.2 days, as compared to 5.9 for "sick" newborns (Table 2.8). The most common diagnoses for "sick" newborns--who constituted 27 percent of newborn discharges--was jaundice (31 percent), prematurity (11 percent), respiratory conditions (11 percent), and congenital anomalies (9 percent).[25]

Neonatal Intensive Care: Neonatal intensive care is a level of "constant and continuous care of the critically ill newborn."[26] It is difficult to define what constitutes neonatal intensive care due to variation in the methods under which hospitals provide this type of care. Generally, neonatal intensive care is offered in organized hospital units with a range in the "sophistication and scope of services they are equipped and staffed to provide."[27] Staff in neonatal intensive care units (NICUs) often have special training in life-saving pediatric care. Given that most complications of newborns are related to prematurity and low birth weight, the most common technologies available in NICUs relate to the developmental problems of newborns. They include: respirators and associated methods of oxygen therapy, intravenous hyperalimentation (i.e., intravenous administration of nutrients), thermoregulatory apparati, cardiac catherization, blood transfusion equipment, and a battery of laboratory testing procedures.

Approximately 6 percent of all live births are admitted to NICU. Factors associated with the use of neonatal intensive care include a number of interrelated factors: low birth weight, a history of little or no prenatal care, race, and socioeconomic status. Evidence suggests that neonatal intensive care has had an effect on reducing the rate of infant mortality and has improved the condition of critically ill infants.[28]

Cost of Neonatal Intensive Care: Determining the cost of neonatal intensive care is difficult because NICUs "are often not separate cost reports in hospital reports, but are mingled with other intensive care or pediatric services" and generally "exclude 'ancillary services' such as laboratory tests, X-rays, and physician fees. Since diagnostic and therapeutic services are a major part of the total costs of caring for neonatal patients, such figures greatly underestimate per capita costs."[29] The average length of stay for neonatal intensive care--according to a Budetti, et al. 1981 review of the neonatal intensive care literature--was 13 days (ranging from 8-18 days).[30] Budetti, et al. also found that the cost of neonatal intensive care in 1978 averaged $8,000 (ranging from $1,800 to $40,000).[31] A 1977 Boston hospital study of NICU babies determined the average cost to be $10,294. A 1976 Denver study determined the average cost as $10,513, with the cost varying by birthweight: the average was $14,020 for infants under 1,500 grams (very low birth weight); $8,575 for 1,500-2,500 grams; and $3,592 for 2,500 grams and above.[32] A 1978 study by Phibbs, et al. examined the cost of neonatal intensive care by the birthweight and found that costs increased as birthweight decreased.[33]

In Texas, a 1980 study at Dallas' Parkland Memorial Hospital examined the utilization of NICU facilities among low birth weight babies in relation to mothers who had and had not received prenatal care. The infants in this study had birth weights between 865-2,220 grams. With an average cost of $1,000 per day for care in NICU, the average total cost for an infant whose mother failed to receive prenatal care was $3,600, as compared to $1,200 for infants whose mothers had received prenatal care.[34] These estimates, however, cover low birth weight infants who may not have been admitted to neonatal intensive care, the costs of which are considerably greater than normal nursery care. [Note: No information was available on the source of payment for neonatal intensive care by the age of the mother.]

## Source of Payment

Due to patient privacy restrictions and competition among hospitals, very little information is available with regard to sources of payment for adolescent pregnancy related services. The most comprehensive information available comes from an October 1983 report based upon the 1980 National Hospital Discharge Survey (NHDS).[35] The report points out that the source of payment for adolescent hospital deliveries contrasted significantly from the source of payment for all adolescent stays -- male and female (see Table 2.14). As Table 2.14 shows, private insurance was the principal source of payment for 63.2 percent of all adolescent hospital stays. However, private insurance was the source of payment for only 36.2 percent of adolescent delivery costs; Medicaid was the principle source of payment for 30 percent of adolescent deliveries -- as compared to 17 percent of all adolescent stays. This may indicate a significant degree of welfare dependency (and low income status) among teenage mothers in that lack of other income resources requires teenage mothers to turn to public assistance. Self payment was twice as likely to be the source of payment for

Table 2.14
Source of Payment
Percent Distribution for
(1) Female Adolescents with Deliveries
(2) All Adolescent Hospital Stays,

Based on Discharges from Short-Stay Hospitals,
U.S., 1980

| Source of Payment | Adolescent Deliveries | All Adolescent Stays |
|---|---|---|
| Private Insurance | 36.2% | 63.2% |
| Medicaid | 30.0 | 17.0 |
| Self Pay* | 21.8 | 10.9 |
| Other Sources** | 12.1 | 8.9 |
| TOTAL | 100.0% | 100.0% |

* Paid by the patient, spouse, parents, and/or next of kin.

** Includes workers' compensation, no charge, and other government payments.

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Source: National Center for Health Statistics, National Hospital Discharges Survey "Utilization of Short-Stay Hospitals by Adolescents: United States, 1980," by Edmund Graves, Advance Data, no. 93, Sept. 14, 1983.

adolescent deliveries as compared to all adolescent hospital stays, which could suggest that, on a national basis, private insurance is not frequently relied on for payment of dependent minor pregnancy expenses.

A 1978 Rhode Island study of the source of payment for deliveries among teenage women -- by socioeconomic status -- reports findings similar to the above study (see Table 2.15).[36] In addition, the socioeconomic status of each teen pregnancy is coded according to the residence of the individual. Private insurance is the source of payment of 38.6 percent of the cases, which approximates the distribution in the 1980 NHDS study. Of teen deliveries to women under 15 (all of whom were unmarried), private insurance was the source of payment for only 18.7 percent of the total (not shown). This study also reveals that teenage pregnancies are disproportionately among low income groups, and again implies that these low income groups are less likely to have private health insurance as a source of payment.

However, the "high" income socioeconomic category, which is logically associated with good health insurance coverage, has private insurance coverage for only 49 percent of its teenage delivery cases. The NHDS and Rhode Island studies <u>are not</u>, however, directly applicable to the study of dependent minor pregnancy insurance in Texas. First, the 1980 NHDS is national in scope; yet, each state is responsible for regulating the insurance industry within its boundaries, and some states choose to mandate private insurance coverage for dependent minors, as will be revealed later in this report. Although Rhode Island does not mandate dependent minor pregnancy insurance, the private insurance market varies from state to state, and different market forces may encourage the provision of this type of coverage. Second, in the NHDS, 47 percent of the adolescent deliveries were to married women, thus placing a significant

Table 2.15

Deliveries to Women 15 - 19 for
Source of Payment
Rhode Island, 1978

| Total | Medicaid | Other Government | Private Insurance | Self-Pay |
|---|---|---|---|---|
| 100% | 19.2% | 26.5% | 38.6% | 14.2% |

Number of deliveries to women 15 - 19
by socioeconomic status,
Rhode Island, 1978

| | | Socioeconomic Status | | | |
|---|---|---|---|---|---|
| | Total | High | Middle | Low | Poverty |
| Number | 1,364 | 145 | 409 | 548 | 262 |

Source: Joy Dryfoos, Adolescent Pregnancy in Rhode Island, Rhode Island Health Services Research, Inc., 1980, Table 16.

proportion of the adolescent population outside of the classification of "dependent minor" in regard to private insurance coverage; in the Rhode Island study, 53.3 percent of adolescent mothers were married at the time of delivery.

The covered individuals (i.e., the 38.6 percent covered by private insurance) may, for the most part, be married women with their own family policies.

## Summary

The consequences of unexpected and unwanted pregnancies among teen women result in higher rates of abortion and--due largely to a failure to receive adequate pregnancy care--to increased rates of pregnancy complications. The failure of pregnant teens to receive prenatal care (because of ignorance and/or an inability to pay) is associated with higher rates of low birth weight babies. Low birth weight, in turn, involves higher health care costs involved in caring for sick newborns--often through the use of expensive neonatal intensive care services.

It is uncertain as to what effect private insurance might play in improving the outcome of a teen pregnancy. This is because of the lack of comprehensive knowledge about service utilization rates and the availability and use of insurance coverage among the Texas population in need. In addition, the cost impact is unknown--including the cost of insurance premiums and the existence of a cost tradeoff between an increased use of cheaper prenatal care versus a possible reduction in the use of expensive neonatal care.

Footnotes

[1] The Alan Guttmacher Institute, Teenage Pregnancy, The Problem That Hasn't Gone Away, 45.

[2] A. Torres, et al., "Telling Parents: Clinic Policies and Adolescents' Use of Family Planning and Abortion Services," Family Planning Perspectives, vol. 12, no. 6 (November/December 1980): 284.

[3] Ibid., 287.

[4] Melvin Zelnik and John Kantner, "Sexual Activity, Contraceptive Use and Pregnancy Among Metropolitan-Area Teenagers: 1971-1979," Family Planning Perspectives, vol. 12, no. 5 (Sept./Oct. 1980), 237.

[5] Melvin Zelnik and John F. Kantner, "Sexual and Contraceptive Experience of Young Unmarried Women in the United States, 1976 and 1971," Family Planning Perspectives, vol. 9, no. 2 (March/April 1977): 69.

[6] Aida Torres and Jacqueline Forrest, "The Costs of Contraception," Family Planning Perspectives, vol. 15, no. 2 (March/April 1983): 71.

[7] The Alan Guttmacher Institute, Abortion Services in the United States, 77.

[8] Henshaw and O'Reilly, "Characteristics of Abortion Patients," Family Planning Perspectives (January/February 1983): 10.

[9] The Alan Guttmacher Institute, Teenage Pregnancy, The Problem That Hasn't Gone Away, 55.

[10] Torres, et al., "Telling Parents," Family Planning Perspectives (November/December 1980): 289-290.

[11] Ibid.

[12] Ibid., 255.

[13] Uta Landy and Sarah Lewit, "Administrative, Counseling and Medical Practices in National Abortion Federation Facilities," Family Planning Perspectives, vol. 14, no. 5 (September/October 1982): 261.

[14] National Center for Health Statistics, "Utilization of Short-Stay Hospitals by Adolescents," Advance Data (Table 6), 5.

[15] Ibid., 2.

[16] U.S. Department of Health and Human Services, Public Health Services, National Center for Health Statistics, "Deliveries in Short-Stay Hospitals: United States, 1980," by Barbara J. Haupt, Advance Data, no. 83 (October 8, 1982), 1.

[17] Ibid., 7.

[18] Paul J. Placek, et al., "Cesarean Section Delivery Rates: United States, 1981," American Journal of Public Health, vol. 73, no. 8 (August 1983): 861.

[19] Ibid.

[20] Malitz, "A Cost-Benefit Analysis of Extending Medicaid Coverage to Provide Prenatal Care to Pregnant Women," May 1983, 11. (Mimeograph.)

[21] Ibid., 5.

[22] Ronald L. Williams, "Measuring the Effectiveness of Perinatal Medicare Care," Medical Care, vol. 17, no. 2 (February 1979): 96, as cited in David Malitz, "A Cost-Benefit Analysis of Extending Medicaid Coverage to Provide Prenatal Care to Pregnant Women," Paper submitted to the Texas Department of Human Resources, May, 1983, 4.

[23] U.S. House, Committee on Human Resources, Adolescent Health Services and Pregnancy Prevention and Care Act of 1978, S. 2910, 95th Cong., 2d session, 1978, 17.

[24] National Center for Health Statistics, "Utilization of Short-Stay Hospitals, United States, 1981, Annual Summary," by E. Graves and B. J. Haupt, Vital and Health Statistics, Series 13, no. 72 (Washington, D.C.: U.S. Government Printing Office, September 1983), 15.

[25] Ibid., 15-16.

[26] American Academy of Pediatrics, Committee on Fetus and Newborn, Standards and Recommendations for Hospital Care of Newborn Infants 1974-1977, 6th ed. (Evanston, IL: American Academy of Pediatrics, 1977) as cited in Peter Budetti, et al., "Case Study #10: The Costs and Effectiveness of Neonatal Intensive Care," The Implications of Cost-Effectiveness Analysis of Medical Technology, Background Paper #2: Case Studies of Medical Technologies (Washington, D.C.: Office of Technology Assessment, U.S. Congress, August 1981), 7.

[27] Ibid.

[28] Ibid., 27-38.

[29] Ibid., 19.

[30] Ibid., 17.

[31] Ibid., 19-21.

[32] Ibid., 9.

[33] C. S. Phibbs, et al., "Newborn Risk Factors and the Costs of Neonatal Intensive Care," Pediatrics, vol. 68 (1981).

[34] Malitz, "A Cost-Benefit Analysis of Extending Medicaid Coverage to Provide Prenatal Care," 10.

[35] U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, "Utilization of Short-Stay Hospitals by Adolescents: United States, 1980," by Edmund J. Graves, Advance Data, no. 93 (September 14, 1983): 3.

[36] Joy G. Dryfoos, Adolescent Pregnancy in Rhode Island, Final Report (Providence, Rhode Island: Rhode Island Health Services Research, Inc., 1980), Table 17.

[37] Health Insurance Association of America, "New Group Health Insurance, Based on Surveys of the Public Relations Division of the Health Insurance Association of America," HIAA Public Relations Division, Washington, D.C., 1984. (Booklet.)

## CHAPTER 3

## PRIVATE INSURANCE COVERAGE OF PREGNANCY EXPENSES

The availability of particular types of health insurance coverage is determined by state regulatory practices and by private insurance underwriting practices. Regulation of the insurance market place, as one factor behind availability, is generally a responsibility of state government. In Texas, the State Board of Insurance enforces the laws governing the insurance industry in such a manner as to protect the public's interest. It is the primary function of the agency to see that consumers are able to find coverage at a fair and reasonable price with the assurance that the insurance contract will be honored.[1]

Insurance underwriting practices act as a second factor in determining what types of insurance coverage are sold, including dependent minor pregnancy-related and newborn care insurance for dependents' offspring. Generally, insurers historically considered pregnancy and childbirth as conditions planned and budgeted by the family. Therefore, they were not generally seen as insurable events for which private insurance could be written. However, the enactment of The Federal Pregnancy Discrimination Act of 1978 greatly affected the insurance industry's treatment of pregnancy benefits for the insured and covered spouses. But coverage of dependent daughters and insurance for the offspring of dependent minors are unique types of coverage distinct from the traditional range of services that are covered under health insurance policies. Underwriting practices for these benefits vary greatly.

This chapter will examine the availability of pregnancy-related and newborn insurance. The first part of the Chapter looks at regulatory policies dealing with pregnancy-related care and newborn care. Following that discussion is a report of the results of the written surveys conducted by the State Board of Insurance, which have shown that dependent minor pregnancy-related insurance--and to a lesser extent, newborn insurance for the offspring of dependent minors--is presently available in a significant number of health insurance policies written in Texas.

## The Federal Pregnancy Discrimination Act of 1978

The Federal Pregnancy Discrimination Act is an amendment to Title VII of the Civil Rights Act which expands the definition of sex discrimination in employment to include "pregnancy, childbirth, or related conditions."[2] Under the Act, employers with 15 or more employees are prohibited from discriminating against pregnant women in terms of employment, compensation, and the provision of employee benefits. This Act is an important event in the history of the extension of employment-related health insurance to include pregnancy and pregnancy-related conditions. Given that group employment-related health insurance is the most common form of health insurance available to Americans, this Act has brought about widespread inclusion of pregnancy in group health insurance plans of 15 or more employees. However, the Federal Pregnancy Act does not extend to dependent minors of covered employees. The Federal Pregnancy Act's relevance to the issue of dependent minor pregnancy insurance is revealed in Employment Opportunity Commission's (EEOC) guidelines on the scope of the Act. Guidelines were published April 20, 1979, in the Federal Register in a "Questions and Answers" format. Question 21 reads as follows:

> Q: Must an employer provide health insurance coverage for the medical expenses of pregnancy-related conditions of... the dependents of all employees?) (emphasis added)

> A: Where an employer provides no coverage for dependents, the employer is not required to institute such coverage.... [t]he insurance does not have to cover the pregnancy-related conditions of non-spouse dependents . . . (emphasis added)3

One insurance carrier that responded to the SBI survey, in discussing the application of the Federal Pregnancy Act to dependents (i.e., spouses, dependent children), states that it will provide "equal coverage for pregnancy-related expenses for dependent children since some states require this coverage, cost is minimal and uniformity is desirable."[4]

## Texas Regulatory Policies

Texas regulatory policies regarding pregnancy-related and newborn insurance coverage involve the interrelated principles of (1) extending equal treatment to men and women in the sale of health insurance; (2) providing minimum standards of health care coverage; and (3) protecting the viability of the insurance marketplace--the latter of which favors a minimal amount of intervention in the competitive health care market. Thus, the ability of the insurance industry to respond to issues of flexibility, diversity, and efficiency in the marketing of health insurance must balance the goal of protecting the insurance-consuming public through maintenance of quality and access to health care to the extent that the marketplace does not promote those principles.

Pregnancy: Complications of Pregnancy: Texas insurance regulations on maternity address that aspect of pregnancy--complications of pregnancy--which is in least conflict with the voluntary condition-risk dichotomy under the principle of insurance. Complications of pregnancy are not "voluntary" and thus meet the traditional definition of an insurable risk. Almost all states have a statute or rule governing the provision of health care for complications of pregnancy. Most of these statutes require that complications of pregnancy be covered "the same as any other illness." Appendix C of this report contains a listing of state statutes on complications of pregnancy.

On May 1, 1978, the State Board of Insurance issued "Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status" to deal with issues of unfair sex discrimination in the provision of insurance. The "Unfair Practices" rules were derived, in part, from a 1975 model regulation developed by the National Association of Insurance Commissioners (NAIC) regarding the elimination of unfair sex discrimination. The "Unfair Practices Based Upon Sex" rules address the issuance of maternity benefits, including terms and conditions and underwriting criteria. Section 059.21.21.105 (A) requires that complications of pregnancy shall be covered under "all individual, group and blanket policies and contracts and individual certificates of insurance delivered or issued for delivery in..." Texas the same as any other illness or sickness under the policy.[5] Thus, complications of pregnancy must be treated the same as any other illness for all covered persons--including covered dependent minors. Complications of pregnancy outlined in the regulation include

> "conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity... non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible."[6]

However, the Board Order states that complications of pregnancy does not include

> "false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy...."[7]

Appendix D contains the complete text of the State Board Orders relevant to complications of pregnancy.

Pregnancy: Oral Contraceptives: An additional provision under the "Unfair Practices Based Upon Sex" rules is the requirement that coverage of oral contraceptives cannot be excluded in policies which provide for coverage of all other prescription drugs (see Appendix D). State Board Order 32447 stipulates that "[n]o insurer may exclude from prescription drug benefits oral contraceptives when all other prescription drugs are covered."[8] Other forms of contraception are not required to be covered under health insurance contract provisions but can be if the insurer chooses to offer the benefit.

Newborn Care: Texas regulatory policy on newborn care developed in a manner similar to complications of pregnancy coverage, whereby a model bill--developed by the American Academy of Pediatrics and the HIAA--was the basis for Texas (and other states) adopting such legislation (see Appendix J). All fifty states and the District of Columbia have newborn statutes which govern the provision of care to newborns. (Appendix E of this report contains a listing of state-by-state newborn care statutes.) Most follow the guidelines of the HIAA model bill, which applies to the newborns of the insured but not necessarily to the newborns of the dependents of the insured (i.e., the grandchildren of policyholders).

Texas regulations stipulate that

> "no individual policy or group policy of accident and sickness insurance...which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child."9

(See Appendix F for Texas Insurance Code and State Board Orders regarding newborn care.)

This regulation requires that policies which cover newborn children cannot exclude or limit initial coverage and cannot exclude coverage of congenital defects of a newborn child. However, some confusion exists as to whether the statute was intended to apply to the newborn children of dependent minors. The NAIC model upon which the Texas statute was based, states that benefits shall be payable with respect to a newly born child of the insured but makes no reference to newly born children of the insured's dependents. However, the Texas statute was

modified and simply requires coverage of a newborn child. By not stipulating a newborn child of the insured, it can be interpreted that the statute applies to any newborn child of a covered individual, including dependents. Since the Board has received no request to consider rules and regulations with regard to this statute and since the statute does not specify whether dependents' offspring are included, it appears that most insurers do not extend benefits to newborn children of dependents.

The purpose of the newborn care provision is to ensure that newborns covered under private health insurance have access to some minimum level of care, particularly to neonatal intensive care--the nature of which is often extremely expensive but without which the infant's survival chances would be poor. However, a "Statement of Principles" developed by the American Academy of Pediatrics (AAP) and the Health Insurance Association of America (HIAA)--the drafters of the Model Newborn Children Bill--states that the provisions of the Model Bill "are not intended to imply, and should not be construed so as to imply, the inclusion of coverage for routine well-baby services."[10] Furthermore, the "Principles" state that mandating routine well-baby care services would have an adverse impact upon the price of health insurance policies. In the words of the "Statement," these services have a definite social and medical value and any provisions for their inclusion should be voluntarily negotiated between insurers and insured.

## Other States' Maternity Laws

Four states have implemented statutes regarding the provision of dependent minor pregnancy insurance: Maine, Minnesota, New York, and Wisconsin (see Table 3.1). (See Appendix G for the complete statutes.) These statutes vary in their applicability and focus. Only one state, New York, requires that all policies

written in the state (individual and group) contain maternity coverage. New York also requires that all family policies cover the pregnancy expenses of dependent minors. The other three states require coverage of dependent minors under family coverage policies in which maternity is covered and apply to individual as well as group policies.

Maine: Under Maine's statutes,[11] the same maternity benefits must be provided to unmarried policyholders and dependent minors of policyholders with dependent minor family coverage as are provided married policyholders or the wives of policyholders.

> "All health insurance policies and plans shall provide...the same maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage under the same terms and conditions as such maternity coverage is provided to married policyholders or the wives of policyholders with maternity coverage."12

Thus, in family policies with dependent minor coverage and with maternity coverage, dependent minors must be covered to the same extent as others under the policy. This requirement applies to all health insurance policies and plans.

Table 3.1

State Dependent Minor Maternity Laws

| | |
|---|---|
| Maine | Maine Insurance Code, 24-A Section 2741, 2832.<br><br>All health insurance plans shall include same maternity benefits to unmarried policyholders and dependent minors of policyholders with dependent minor family coverage as are provided married policyholders or the wives of policyholders. |
| Minnesota | Minnesota Insurance Laws, Section 62A.041, Section 62C.14 Subsection 5a.<br><br>All individual and group plans shall include the same maternity benefits to unmarried women policyholders and minor female dependents covered under family policies as are provided married women. |
| New York | New York Insurance Laws, Sections 162-a, 164-a, 253 1-a.<br><br>Maternity coverage included in all health insurance contracts; maternity coverage for all females covered under the policy. |
| Wisconsin | Wisconsin Insurance Laws, Section 632.895(7).<br><br>Group disability policies which cover dependent children and cover maternity for any individual shall provide maternity benefits for dependent children. |

Minnesota: Minnesota's statutes require all individual and group health policies to provide the same maternity benefits to unmarried women policyholders and minor female dependents covered under family policies as are provided married women.[13]

> "Each group policy of accident and health insurance shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage.
>
> Each individual policy of accident and health insurance shall provide the same coverage for maternity benefits to unmarried, women and minor female dependents as that provided for married women."14

Originally passed in 1971 as a mandated offering of optional maternity coverage, the statute was amended in 1973 to require coverage in those policies with maternity coverage.

New York: New York's maternity coverage statutes do not directly address dependent minors but rather require all individual and group health insurance policies issued in the State to provide maternity coverage.[15]

> "Every policy subject to the provisions of [group accident and health policies AND individual accident and sickness policies] which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy...."16

Circular Letter No. 23 (1976) of the State of New York Insurance Department further clarifies applicability to dependent minors in a Question/Answer format.

> [Question] 10. Does Chapter 843, Laws of 1976 [requirement for maternity care to the same extent as coverage is provided for illness or disease under the policy] require maternity coverage for every female covered under the contract?
>
> YES. The law specifically requires maternity care coverage be provided in "Every policy..." without any restrictions based on age, sex, or marital status."17

Wisconsin: The most recently-passed statute dealing with dependent minor maternity coverage, Wisconsin requires group disability policies covering dependent children and covering maternity to provide maternity benefits for dependent children.

> "Every group disability policy which provides coverage of dependent children and maternity coverage for any individual shall provide maternity coverage for dependent children. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy."18

## Survey Results

On the basis of testimony, the Texas Select Committee on Teenage Pregnancy arrived at findings on private health insurance coverage of dependent minor pregnancy-related and newborn care expenses. The Committee found that "most private medical insurance carriers do not cover pregnancy and delivery to the dependent minors of policyholders..." and never cover

the newborn grandchild of the policyholder.[19] In further examining private insurance carrier coverage practices, the Research and Information Services Division of the State Board of Insurance conducted written surveys of private health insurance carriers and Health Maintenance Organizations (HMOs)--the two largest components of the private health insurance industry. To the extent that coverage is presently being underwritten, regulatory action becomes less relevant as a means for extending coverage. These surveys found that dependent minor pregnancy-related insurance is, in fact, available. Newborn care for grandchildren is also available, albeit not as widely.

Two surveys were developed by Research and Information Services: one for private health insurance carriers and one for HMOs. (The written surveys are included in Appendix H of this report.) The surveys were mailed in March 1984 to the 13 Texas-licensed HMOs (see Table 3.10) and to 25 of the 28 largest private health insurance carriers in Texas, with a few exceptions. (Note: three of the largest Texas health insurance carriers were excluded from this survey because they exclusively underwrite the following: Medicaid, disability income, and self insurance.) (see Table 3.2)

Selection of the surveyed carriers was determined by the size of their accident and health insurance direct premium volume. Direct premium volume measures the gross amount of insurance (including reinsurance) underwritten by a company. The 25 surveyed health insurance carriers represent 71.8 percent of Texas' 1982 direct accident and health insurance premium volume. Of the surveyed insurers, 23 private health insurance companies and 11 HMOs responded. The 23 responding private carriers represent 70.3 percent of the 1982 direct health insurance premium volume in Texas. The largest 25 private carriers were selected for two reasons: (1) given that they represent such a large proportion of the total private health

insurance business, they provide a significant measure of insurance industry underwriting practices; and (2) economy of resources precluded surveying the approximately 364 carriers licensed in Texas. It is possible that the 25 largest carriers may not reflect the underwriting practices of smaller carriers. Therefore, no comparisons will be made between the practices of the survey population and the total health insurance population. Instead, survey results will be discussed solely in terms of the survey population.

The structure of the written surveys included questions on present and past practices regarding coverage of (1) dependent minor pregnancy-related expenses and (2) newborn care expenses for the offspring of dependent minors--including the availability, scope of services, and costs of coverage. Dependent minor pregnancy-related expenses include services attributable to the pregnant woman: prenatal care, delivery, complications of pregnancy, diagnostic tests, abortion, family planning, and contraception. Newborn care expenses are associated with infants and include newborn nursery care (i.e., care associated with the initial delivery and hospital stay), neonatal intensive care, and well baby care (i.e., post-delivery pediatric care for the infant).

Private carriers were surveyed as to their coverage under group health plans, which represent the vast majority (approximately 83 percent in 1975) of private health insurance coverage.[20] The survey did not address coverage of maternity under individual plans. Maternity coverage under individual policies is prohibitively expensive given that adverse selection would occur in the purchase of this benefit; the cost of such coverage is not spread over a pool of persons larger than the group most likely to need or use maternity services. HMOs offer a standard policy or a standard set of high and low options to all enrollees. Any decision by an HMO to include this type of coverage will thus be based upon a determination of the group's characteristics.

Health insurance policies vary from group to group given that policies are underwritten according to the particular characteristics and needs of different groups. Therefore--beyond determining whether or not coverage was available--it was difficult to gather information on benefit restrictions, copayment requirements, and premium rate costs. Furthermore, information on the percentage of a carrier's business with coverage and the number of persons with coverage was often unavailable since private insurers are not required to collect this information and given that it is difficult for carriers to collect this information.

## Private Carrier Survey - Dependent Minor Pregnancy-Related Services

Availability: Table 3.2 lists the 25 private health insurance carriers that were surveyed in Texas under which dependent minor pregnancy insurance is frequently provided. Of the 23 reporting respondents, 17 cover dependent minor pregnancy-related care (i.e., pregnancy-related update coverage applicable to the teenage mother, exclusive of newborn care coverage). Two companies that provide coverage are of the opinion that the Federal Pregnancy Discrimination Act requires coverage of dependent minors. Four carriers do not provide coverage. Among those that do not provide this type of coverage, one reports previously providing coverage (see Table 3.3). The Federal Pregnancy Discrimination Act may have had some influence on the extent of coverage for dependent minors, given that the expansion in maternity coverage for women in general may have extended as well to dependent minors.

Table 3.2

Private Health Insurance Carrier Survey Population
25 Major (Largest) Private Health Insurance Carriers*
as Measured by Texas Group Accident and Health Direct
Premium Volume, 1982 by Premium Volume

| Carrier | | Group Accident and Health - Premium Written by Company (9/12/83) |
|---|---|---|
| Blue Cross Blue Shield: | | |
| - Group Hospital Services, Inc. (Blue Cross) | $677,484,055.00 | |
| - Group Life and Health (Blue Shield) | $102,298,812.00 | |
| Total: | | $ 779,782,867.00 |
| Prudential Insurance Company | | 245,396,012.00 |
| Aetna Life Insurance Company | | 193,333,500.00 |
| Travelers Insurance Company | | 146,378,542.00 |
| Connecticut General Life | | 77,836,000.00 |
| Republic National Life | | 64,775,310.00 |
| Equitable Life Assurance | | 59,475,989.00 |
| Pilot Life Insurance Co. | | 55,865,240.00 |
| Bankers Life Co. of Iowa | | 52,968,812.00 |
| Southland Life Insurance Company | | 52,678,638.00 |
| Metropolitan Life Insurance Co. | | 43,372,822.00 |
| Southwestern Life Insurance Co. | | 39,993,056.00 |
| American General Life | | 35,641,885.00 |
| Mutual Benefit Life Insurance Co. | | 32,032,856.00 |
| Lincoln National Life | | 31,909,699.00 |
| John Hancock Mutual Life | | 30,393,388.00 |
| United of Omaha Life | | 30,366,463.00 |
| Transamerica Occidental | | 28,004,271.00 |
| General American Life | | 27,911,423.00 |
| Union Labor Life | | 24,418,888.00** |
| Provident Life and Accident | | 23,934,797.00 |
| G.I.C. Insurance | | 22,006,555.00 |
| Massachusetts Mutual Life | | 21,927,803.00** |
| Mutual Life | | 21,155,166.00 |
| Allstate Insurance Co. | | 21,106,650.00 |
| Total - 25 largest carriers | | 2,162,666,632.00 |
| Total - all accident and health insurance carriers | | 3,010,392,706.00 |

* Excludes 3 carriers that underwrite accident and health for only Medicaid, disability income, and self insurance

** no response received

Source: Texas State Board of Insurance, Group Accident & Health Premium Written by Company 9/12/83. (Tables.)

Table 3.3

Coverage of Pregnancy Related and Newborn Care of 23 Major Private Health Insurance Carriers (as Measured by Texas Group Accident and Health Direct Premium Volume, 1982)

Total responses: 23 out of 25 carriers

| Dependent Minor Pregnancy-Related Coverage | | Newborn Care Coverage | |
|---|---|---|---|
| Covered | 19 | Covered | 7 |
| Not covered | 4 | not covered | 16 |
| previously covered | (1) | | |
| **Covered as part of:** | | **Covered as part of:** | |
| basic contract | 14 | basic contract | 5 |
| option by rider | 3 | option by rider | 2 |
| other | 1 | | |
| unknown | 1 | | |
| **Services Covered:** | | **Services Covered:** | |
| delivery | 19 | newborn nursery | 5 |
| complications of pregnancy* | 23 | neonatal intensive care | 7 |
| prenatal | 19 | well baby care | 4 |
| diagnostic tests | 19 | | |
| abortion (therapeutic) | 19 | | |
| family planning | 2 | | |
| contraceptives | 16 | | |

* For all carriers, "complications of pregnancy" are required to be covered under the basic contract

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted March - July 1984).

The 19 carriers providing pregnancy-related coverage represent 93.15 percent of the premium volume of the top 23 responding carriers (hereafter referred to as "top premium volume"). Fourteen of these 19 carriers provided information on the percentage of their business with coverage, thus presenting a more-refined description of the extent of coverage (see Table 3.4). (Nine carriers reported that between 95-100 percent of their policies contain dependent-minor pregnancy-related coverage. Two carriers stated that "nearly all" and the "vast majority" of its policies include coverage. Three carriers include coverage under 20 percent, 54.7 percent, and 64 percent of their business.) Therefore, these 14 carriers account for coverage representing 60.2 percent of the survey population's top premium volume (see Table 3.4).

The form under which coverage is provided, either as part of the basic contract or as an option by rider, is an important consideration in that coverage as an option suggests less-widespread coverage. This is because policyholders are not as likely to select the option and thus pay the resulting premium rate increment. Of the 19 carriers that provide coverage, 14 do so as part of the basic contract and two provide coverage as an option. One carrier provides 47.6 percent of its total as part of the basic contract and 52.4 percent as an option. Two carriers were unable to provide this information.

Fourteen out of 19 carriers were able to provide information on the percentage of their business with coverage under basic or optional plans, thus providing partial estimates on the percentage of premium volume under these categories. Table 3.4 and 3.5 show the percentage of top direct premium volume with coverage under basic and optional provisions, wherein an estimated 62.6 percent of the top Texas health insurance premium volume included dependent minor pregnancy-related coverage as part of the basic contract; .7 percent included coverage as an option.

Table 3.4

Extent of Coverage
Pregnancy-Related Care
25 Major (Largest) Private Health Insurance Carriers
(as Measured by Texas Group Accident and Health
Insurance Direct Premium Volume*, 1982)

Direct premium volume, as percent of total, Texas 1982

| | |
|---|---|
| - 25 surveyed carriers (of 364 carriers in Texas) | 71.8% of total premium volume |
| - 23 responding carriers | 70.3% |

Extent of Coverage, as measured by % of premium volume of 23 responding carriers

| | |
|---|---|
| - 19 carriers that provide coverage | 93.5% (of 70.3%) |
| - 14 of 19 carriers providing information on the % of their business with coverage (see Table 3.6 for details) | 60% (of 70.3%) |

Type of Coverage, as part of basic contract or as an option

Total of 19 carriers

| | |
|---|---|
| - basic | 14 |
| - option | 3 |
| - combined | 1 |
| - unknown | 1 |

| | |
|---|---|
| - basic (13** of 14 carriers providing information on % of business with coverage) | 62.6% (of 70.3%) |
| - option (2** of 14 carriers providing information on % of business with coverage) | .7% (of 70.3%) |
| - total | 63.3% (of 70.3%) |

-- no information (5 carriers)

* direct premium volume = gross premium volume
** includes carrier that splits coverage between basic and optional categories

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy-Related Expenses of Dependent Minors" (conducted March - July 1984)

Services Covered: Carriers were asked about the types of pregnancy-related services covered and any applicable benefit restrictions on the following: delivery, complications of pregnancy, prenatal care, diagnostic testing, abortion, family planning, and contraceptives (see Table 3.3). [NOTE: It is important to note that the open-ended nature of the survey allowed for carriers to provide a range of detail in supplying information on services and conditions of coverage. Thus, not all carriers provided detail on the conditions of coverage. The fact that policy provisions vary by group also makes it difficult to indicate general conditions of coverage.] Unsurprisingly, all 23 respondents cover complications of pregnancy, as required by Texas insurance regulations. Other services most often covered are delivery, prenatal care and diagnostic testing, wherein all 19 "yes" respondents cover these services. Diagnostic testing is probably restricted to those situations under which testing is necessitated by complications of the pregnancy. One plan defines diagnostic testing, in part, as follows:

> Diagnostic tests and genetic counseling - covered when performed during the 16th to 18th week of pregnancy the same as diagnostic tests for any other disease, as follows:
>
> 1. Expenses for positive pregnancy tests.
> 2. Amneocentesis and alpha-fetoprotein when there is evidence of the following indicators:
>
>    - increased chance of the child being born with Down's syndrome.
>
> 3. Sonograms performed when there is evidence of the following indicators:
>
>    - early symptoms of abnormal pregnancy, gestational development is in question, as in high risk pregnancies or abnormal symptoms.

All 19 carriers cover abortion. Although only four carriers indicate that they restrict coverage to therapeutic abortions, it is a safe assumption--according to the Policy Approval Division of the State Board of Insurance--that most policies cover abortion based upon this restriction.

Sixteen of the 19 carriers cover contraceptives. There is some ambiguity in the responses given regarding the conditions of coverage. Nine carriers state that they will cover only oral contraceptives; two of these state that they will cover oral contraceptives only if their use is medically necessary (e.g., in order to prevent a pregnancy to a woman who is incapable of surviving maternity). However, the regulation regarding the provision of oral contraceptives[21] (whereby, in policies that contain prescription drug coverage, oral contraceptives are covered the same as any other prescription drug) does not restrict coverage to medically-necessary uses. One carrier indicated that its restriction to medically-necessary uses is consistent with its basis for coverage of all other prescription drugs. Six carriers did not specify the conditions under which they cover contraceptives.

Of all the services, family planning is the least likely to be covered. This is not surprising given the various interpretations of "family planning." Sixteen of 19 carriers do not cover family planning, although one of the "no" respondents will cover family planning as part of general counseling (i.e., as part of a physician visit). One carrier that covers family planning will do so, depending upon the license (e.g., private physician, Planned Parenthood) of the family planning provider. Another carrier reports that family planning benefits are optional.

Cost of Reimbursement: Information on the average reimbursement and the number of claims was largely unavailable. Only four carriers were able to provide data on average reimbursement claims: $1,196.04, $2,360 (including $1,600 hospital and $760 professional), $2,035, and $2,250. In addition, only two carriers provided information on the number of claims reimbursed: 1,864 and 870 (estimates) in 1983. This is a significant proportion of the total number of out-of-wedlock births among teen women (5.4 percent of the total number in 1982); these two carriers represent 8 percent of the 1983 accident and health insurance premium volume of the largest 25 carriers in Texas.

Premium Costs: Eight carriers could not provide information on the premium rate costs for dependent minor pregnancy-related care. This situation partially reflects the practice of most carriers of not calculating a separate premium rate for pregnancy-related services to dependent minors.

Four carriers specifically state that the company cannot calculate a specific premium rate increment for dependent minor pregnancy-related care. The seven carriers that do calculate an added premium vary as to their charge (see Table 3.6). For example, one carrier loads its maternity premium by one percent of the dependent premium rate and another as .6 percent of the dependent child rate. These definitions are imprecise measures of the premium rate cost given that they vary from carrier to carrier. However, the nature of the underwriting process of private health insurance carriers (under which there is wide variation in the type of coverage provided, number of policyholders, age of policyholders, etc.) precludes a more exact measure of premium costs.

## Private Carrier Survey - Newborn Care

Availability: Newborn care for the offspring of dependent minors is less likely to be covered relative to pregnancy-related coverage for dependent minors. Only seven of the 23 carriers cover newborn care for the grandchild of policyholders. Three of the 7 indicate that the grandchild must be principally supported by the policyholder (e.g., the grandchild is foster child of policyholder). One carrier provides coverage at an additional premium at the option of the policyholder. Thus, only three carriers provide outright newborn care for grandchildren (see Table 3.6).

The seven carriers covering newborn care represent 64.82 percent of the 1982 top direct premium volume in Texas (see Table 3.7). Five of the seven carriers provided information on the percentage of their business with coverage. All five of these carriers provide coverage as part of the basic contract. By calculating the percentage of their business with coverage, it can be estimated that 41.03 percent of the top volume includes newborn care for grandchildren. Two of the seven carriers offer coverage as option by rider. One states that "very few" of its policies contain this coverage (see Table 3.8). One "no" respondent previously offered coverage as an option.

Services: Of the seven carriers that cover newborns, four cover newborn nursery care (i.e., hospital nursery care for the infant the first few days after delivery). One of the three that do not cover newborn nursery care states that such coverage is available but not frequently purchased. One carrier will only cover newborn nursery care from the 14th day of birth unless certain congenital defects (as stated in Texas' newborn care statute) are present.

Table 3.5

Extent of Coverage
Pregnancy-Related Care
25 Major Private Carriers,
Calculations on Percentage of Business with Coverage
as Part of Basic Contract or as an Option

| Carrier | % of Business | Basic Contract | Option | Premium Volume that includes Coverage | |
|---|---|---|---|---|---|
| Carrier | 100% | 100% | | $ 43,372,822.00 | |
| Carrier | 100 | 100 | | 21,155,166.00 | |
| Carrier | 100 | 100 | | 77,836,000.00 | |
| Carrier | 100 | 100 | | 23,934,797.00 | |
| Carrier | 99 | 100 | | 35,285,466.15 | |
| Carrier | 99 | 100 | | 31,590,602.01 | |
| Carrier | 99 | 100 | | 144,914,756.00 | |
| Carrier | 95 | 100 | | 56,502,189.55 | |
| Carrier | 95 | 100 | | 233,126,211.40 | |
| Carrier | (90)* | 100 | | 47,671,930.80 | |
| Carrier | (90)* | 100 | | 25,120,280.70 | |
| Carrier | 64 | 100 | | 499,061,034.88 | |
| Carrier | 20 | | 100 | 6,073,292.60 | |
| Carrier | 54.7 | 47.7 | 52.4 | 17,521,972.00 | |
| | | | | 8,340,458.70 | (basic) |
| | | | | 9,181,513.30 | (option) |
| Carrier | UK | 100 | | 21,106,650.00 | |
| Carrier | UK | -- | -- | 193,333,500.00 | |
| Carrier | UK | . | UK | 28,004,271.00 | |
| Carrier | UK | 100 | | 55,865,240.00 | |
| Carrier | UK | | virtually all | 64,775,310.00 | |

* estimated from response given on survey, which indicated that "nearly all" and the "vast majority" included coverage

UK - unknown

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Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (conducted March - July 1984)

Table 3.6

Dependent Minor Pregnancy-Related Care
Premium Rate Costs - 1982
Private Health Insurance Carriers, Texas

| Carrier | Premium Rates are Calculated Using the Following Guidelines: |
|---|---|
| Carrier 1 | Premium rate is set at .5-7% of the total claims for children's hospital and medical charges |
| Carrier 2 | .6% of the dependent child premium is included for payment of dependent minor pregnancy costs |
| Carrier 3 | $8-11 of each employee's annual premium is for dependent minor pregnancy-related claims (under group of 100 lives, comprehensive medical plan) |
| Carrier 4 | An additional 1 percent of total premium is added to cover costs of dependent minor pregnancy-related care |
| Carrier 5 | An additional 1 percent of the dependent premium rate is added ($5.50 per year) |
| Carrier 6 | Premium is included as part of total premium for maternity-related costs |
| Carrier 7 | $6.50 per year |
| Carriers 8-11 | No special added premium |
| Carriers 12-19 | Information not available |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted (March-July 1984)

Table 3.7

Extent of Coverage
Newborn Care
25 Major (Largest) Private Health Insurance Carriers
(as Measured by Texas Group Accident and Health
Direct Premium Volume, 1982)

Percentage of Direct Premium Volume, Texas 1982

| | | |
|---|---|---|
| - 25 surveyed carriers (of 364 carriers in Texas) | 71.8% | of premium volume |
| - 23 responding carriers | 70.3% | |

Extent of Coverage as Measured by % of Direct Premium Volume of 23 Responding Carriers

| | |
|---|---|
| - 7 carriers that provide coverage | 64.82% (of 70.3%) [responding carriers] |
| - 5 of 6 carriers providing information on the % of their business with coverage (see Table 3.8 for details) | 41.03% (of 70.3%) [responding carriers] |

Type of Coverage as Part of Basic Contract or as Option

Total of 7 carriers
- basic 5
- option 2

| | |
|---|---|
| - basic (5 of 5 carriers providing information on % of business with coverage) | 41.03% (of 70.3%) [responding carriers] |
| - option (2 carriers) | unknown |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (conducted March - July 1984)

All seven carriers cover neonatal intensive care. Two carriers cover well baby care routinely (i.e., post-hospital pediatric care for the infant) but will do so only if the infant is added to the policy as a dependent. Three carriers offer well baby care as an option.

Premium Costs: No carriers were able to provide information on the average reimbursement or the number of claims reimbursed. In reference to premium rate costs, two carriers indicate that there is no added premium rate charge. One carrier indicates that, in group policies of 100 lives under comprehensive medical plans, the cost per employee is $18-23 for all newborn costs. Four carriers are unable to provide premium rate information (see Table 3.9).

HMO Survey - Dependent Minor Pregnancy-Related Care

Availability: Table 3.10 lists the 13 Texas-licensed HMOs that were surveyed. Of the 11 responding HMOs, all cover dependent minor pregnancy-related care. As of December 31, 1983, there were 276,789 enrollees under these 11 HMOs.

Services and Costs: All 11 HMOs cover the following services: delivery, complications of pregnancy, prenatal care, diagnostic services, abortion, and family planning (see Table 3.11). This is a more widespread level of coverage than that offered by private health insurance carriers. One possible explanation is that the nature of HMOs as self-contained service providers makes them conducive to offering a comprehensive range of pregnancy-related services.

Table 3.8

Extent of Coverage
Newborn Care
Calculations on Percentage of Business with Coverage
as Part of Basic Contract or as an Option

| Carrier | % of Business | Basic Contract | Option | Portion of Premium Volume that includes coverage |
|---|---|---|---|---|
| Carrier | 64% | 100% | | $499,061,090 |
| Carrier | 95 | 100 | | 245,396,012 |
| Carrier | 95 | 100 | | 56,502,190 |
| Carrier | 100 | 100 | | 43,372,822 |
| Carrier | 100 | 100 | | 23,934,797 |
| Carrier | UK | | UK | --- |
| Carrier | UK | | very few | --- |

UK - unknown

---

Source: Texas State Board of Insurance Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (conducted March - July 1984)

Table 3.9

Premium Rate Costs - 1982
Newborn Care
Private Health Insurance Carriers, Texas

| | | |
|---|---|---|
| 1. | | $18-23 annually per employee (for all costs in group plans of under 100 lives, comprehensive medical plans) |
| 2. | 2 carriers | no added premium rate charge |
| 3. | 4 carriers | information not available |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted March - July 1984).

Table 3.10

Health Maintenance Organization (HMO)
Survey Population
(13 Texas-licensed HMOs, 12/31/83)

| Health Maintenance Organization (HMO) | Members |
|---|---|
| Prudential Health Care (Prucare) Plan, Inc. | 101,480 |
| Prucare's Austin Division | 37,714 |
| Good Health Plus, Inc. | 34,314 |
| Metrocare | 2,414 |
| Kaiser Foundation Health Plan of Texas | 45,887 |
| Medcon, Inc. | 3,606 |
| CIGNA Healthplan of Texas, Inc. | 34,000* (7/1/83) |
| CIGNA Healthplan's of Houston Division | 4,000* (7/1/83) |
| Central Texas Health Plan, Inc. | 16,765 |
| Centroplex Health Plan, Inc. | 13,987 |
| North Texas Medicare, Inc. | 2,695 |
| Alternative Delivery Systems of Texas, Inc. | 6,023 |
| Maxicare Texas, Inc. | 11,904 |

* No response received

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Sources: (7/1/83) Texas State Board of Insurance, "Texas HMO Status Report."

(12/31/83) Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted March - July 1984).

Two HMOs indicate that they will cover abortion only if the individual is "at risk" or is a victim of incest. Nine HMOs cover contraceptives. One HMO will cover only oral contraceptives and one will cover contraceptives only if they are medically necessary.

There is a range in the charges involved, depending on the HMO and the high versus low options in force (see Table 3.12). Several carriers do not distinguish between a high and low option, choosing instead to offer a standard policy. For all services, there is a range in charges, including "no charge", "per office visit charge", and "standard charge". Delivery and complications of pregnancy have the highest costs. Of the eight HMOs providing information on charges, three cover delivery and complications of pregnancy at "no charge" under the standard or low option; one additional carrier requires "no charge" under its high option. Seven of the eight HMOs charge from $0-$8.00 per prenatal care visit under standard or low options. Three HMOs require no prenatal copayment per visit under the high option. Similar arrangements exist for diagnostic testing.

Only six HMOs provide information on the charges involved for abortion services. Two have copayments of $5-8.00 under their low and high option plans. One HMO has a copayment of $5.00 under its low option and "no charge" under its high option. One HMO has a standard charge of $185 for an abortion, which is the approximate cost of an abortion in a nonhospital clinic. Two HMOs have a standard "no charge" for abortion.

Table 3.11

HMO Survey Results

Coverage of Pregnancy-Related and Newborn Health Care

| Pregnancy-Related Care | | Newborn Care | |
|---|---|---|---|
| covered | 11 | covered | 4 |
| not covered | 0 | not covered | 7 |
| **Services Covered:** | | **Services Covered:** | |
| delivery | 11 | newborn nursery care | 4 |
| complications of pregnancy | 11 | neonatal intensive care | 4 |
| prenatal care | 11 | well baby care | 4 |
| diagnostic testing | 11 | | |
| abortion (therapeutic) | 11 | | |
| family planning | 11 | | |
| contraceptives | 9 | | |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted March - July 1984).

Table 3.12

HMO Survey Results
Coverage of Pregnancy-Related Care Under
Low Options, High Options, and Standard Options

LOW OPTION

| | No Charge | $0-10 | $0-500 | Other/no info. |
|---|---|---|---|---|
| delivery | 1 | | | 3 (2 at $100 co-pay and 1 at 20% co-pay |
| complications of pregn. | 3 | | | 1 (max $500 co-pay) |
| prenatal care | 1 | 3 | | |
| diagnostic tests | 1 | 3 | | |
| abortion | | | | 2 |
| family planning | 1 | | | 2 |
| contraception (oral) | | 3 | | 1 (20% co-pay) |

HIGH OPTION

| | No Charge | $0-10 | $0-500 | Other/no info. |
|---|---|---|---|---|
| delivery | 5 | | | |
| complications of pregn. | 5 | | | |
| prenatal care | 2 | 3 | | |
| diagnostic tests | 2 | 3 | | |
| abortion | 2 | 2 | | 1 (benefit vary by group) |
| family planning | 2 | 2 | | 1 |
| contraception (oral) | | 3 | | 2 (20% copay) |

STANDARD OPTION

| | No Charge | $0-10 | $0-500 | Other/no info. |
|---|---|---|---|---|
| delivery | 1 | | 1 | 3 (1 at $25 co-pay) |
| complications of pregn. | 1 | 1 | 1 | 2 (1 at $25 co-pay) |
| prenatal care | 1 | 2 | | 2 |
| diagnostic tests | 3 | 1 | | 1 |
| abortion | 3 | | | 2 (1 at $185 co-pay) |
| family planning | 2 | 2 | | 1 |
| contraception (oral) | | 3 | | 2 |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Availability for Prenancy Related Expenses of Dependent Minors" (survey conducted March-July 1984).

Family planning and contraceptives usually involve a copayment up to $10 per visit/per prescription. All nine HMOs that cover contraceptives charge for contraceptive supplies (e.g., birth control pills, IUDs). Six of the seven HMOs providing information on family planning require a copayment up to $5 per visit under the low option; one HMO has a standard "no charge." One HMO has a "no charge" under its high option.

Premium Rate Costs: All 11 HMOs are unable to provide information on premium rate costs for dependent minor pregnancy-related care. Two HMOs state that the cost is part of the basic contract. One HMO states that dependent minor coverage has a "negligible" effect on premium rates.

## HMO Survey - Newborn Care

Availability: Of the 11 responding HMOs, only four cover newborn care for the grandchildren of policyholders. (Two HMOs previously offered coverage of grandchildren.) None of the HMOs were able to provide information on the number of newborns of dependent minors covered for newborn care. Of the four HMOs offering newborn care coverage, all four cover newborn nursery care, neonatal intensive care, and well baby care. The conditions of coverage vary under each plan.

- One HMO will cover these services only if full parental responsibility is established for the grandchild.
- One HMO will cover these 3 services only while the mother is hospitalized.

- One HMO will cover all 3 services and will cover well baby care only if the grandchild is added as a dependent of the subscriber.

- One HMO will cover all 3 services for up to 31 days and will cover well baby care after the 31st day only if the subscriber becomes a legal guardian of the newborn.

Services and Costs: Charges vary for newborn care under the low, high, and standard options of the four HMOs offering coverage. Table 3.13 shows the range in the charges of these 4 HMOs.

Premium Rate Costs: None of the HMOs offering newborn care are able to provide information on the number of cases, the average cost, or the premium rate costs.

Table 3.13

HMO Survey Results
Coverage of Newborn Care Under
Low Options, High Options, and Standard Options

LOW OPTION

| | No Charge | $0-500 | Other |
|---|---|---|---|
| Newborn Care | 1 | | 1 (20% co-pay) |
| Neonatal Intensive | | 1 (500 max co-pay) | 1 |
| Well Baby | | | 1 |

HIGH OPTION

| | No Charge | $0-10 | $0-500 | Other |
|---|---|---|---|---|
| Newborn Care | 2 | | | |
| Neonatal Intensive | 1 | | 1 (500 max co-pay) | |
| Well Baby | 1 | | | 1 |

STANDARD OPTION

| | No Charge | $0-10 | $0-500 | Other |
|---|---|---|---|---|
| Newborn Care | 2 | | | |
| Neonatal Intensive | 2 | | | |
| Well Baby | | 2 | | |

Source: Texas State Board of Insurance, Research and Information Services, "Survey of Insurance Availability for Pregnancy Related Expenses of Dependent Minors" (survey conducted March-July 1984).

## Summary of Survey Results

The findings of the survey are in contrast to the assumption of the Select Committee and HCR 84, wherein dependent minor pregnancy-related care and--to a lesser extent, newborn care for grandchildren--is covered in a significant number of policies. Given that some coverage is available, the necessity of requiring optional coverage must be carefully considered. The survey also revealed problems of non-compliance with statutes concerning the coverage of prescribed oral contraceptives, as well as in the provision of newborn child benefits. These problems are addressed in Chapter Four.

The demographics of the teenage pregnancy population provide perspective on the magnitude of the problem. Particular variables include the trend in the number of pregnancies, births, and abortions; the age distribution of pregnant teens (i.e., a partial proxy for dependency status); the number of out-of-wedlock births; the role of the family; and the health characteristics (i.e., low birth weight, lack of prenatal care) of teen pregnancies. The medical costs involved provide a measure of the financial burden that may accompany a teen pregnancy as it effects families and the private insurance market.

Finally, the nature of the insurance market, the nature of health insurance regulation, and present insurer underwriting practices help determine the proper regulatory response. The next chapter will examine these factors in discussing the basis from which to arrive at a regulatory decision.

Footnotes

[1] Robert Mehr and Emerson Cammack, The Principles of Insurance (Homewood, IL: Richard D. Irwing, Inc., 1976), 3.

[2] Public Law 95-555, 92 Stat. 2076, "The Federal Pregnancy Discrimination Act" (October 1978).

[3] "Guidelines on Sex Discrimination; Adoption of Final Interpretive Guidelines; Questions and Answers" (The Federal Pregnancy Discrimination Act), Federal Register 20 CFR Part 1604, April 20, 1979: 23804-23809.

[4] Prudential Group Insurance Department. "Group Focus On Laws and Regulations." vol. 4, no. 3 (March 1979): 1.

[5] Texas State Board of Insurance, "Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status," State Board Order 33888, June 30, 1977.

[6] Texas State Board of Insurance, "Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status," State Board Order 32447, Section 059.21.21.105 (A) (1) (2), June 30, 1977.

[7] Ibid.

[8] Ibid., Section 059.21.21.104 (C).

[9] Texas Insurance Code, Article 3.70-2(E) (Added by Acts 1973, 63rd Leg., P. 1076, ch. 413 Section 1).

[10] American Academy of Pediatrics/Health Insurance Association of America, "Statement of Principles concerning Legislation for Newborn children Coverage in Health Insurance Policies." (Mimeograph.)

[11] Main Insurance Code, 24-A, Sections 2318, 2741, 2832.

[12] Main Insurance Code, Section 2741, 24-A.

[13] Minnesota Insurance Laws, Sections 62A.041, 62C.14 subsection 5a.

[14] Minnesota Insurance Laws, Section 62A.041.

[15] New York Insurance Laws, Sections 162-a, 164-a, 253 1-a.

[16] Ibid., Sections 162-a, 164-a.

[17] New York Insurance Department, Circular Letter No. 23 (1976), Mandatory Maternity Coverage, December 3, 1976.

[18] Wisconsin Insurance Laws, Section 632.895 (7).

[19] Texas House of Representatives, Select Committee on Teenage Pregnancy, Interim Report, 32.

[20] U.S. Department of Health and Human Services, National Center for Health Services Research, National Health Care Expenditures Study, "Employer and Employee Expenditures for Private Health Insurance," Data Preview 7 (June 1981), 3.

[21] Texas State Board of Insurance, "Unfair Practices Based Upon Sex," State Board Order 32447.

## CHAPTER 4

## MANDATED BENEFITS

The concerns behind this feasibility study--as expressed by the Select Committee on Teenage Pregnancy and subsequently through HCR 84--are for ensuring an optimal pregnancy outcome for the pregnant teen woman and for reducing the financial burden that a teen pregnancy may place upon the family of a pregnant teen. At question is whether or not these concerns can and should be addressed by the private health insurance market. Broadly speaking, there are two issues to consider in making such a determination: unmet need and cost impact. The National Association of Insurance Commissioners (NAIC) identified these points, among others, in a report of an advisory committee on mandating benefits.[1] In September 1984, the Texas House Insurance Committee, voted to recommend to the Texas Legislature that all future mandated benefits legislation be evaluated according to NAIC criteria. These criteria are as follows:

- The legislation fills a clear, current need.
- Consideration is given to short term and long term costs to consumers and to the impact on total health care expenditures.
- Measures are taken to minimize overutilization (and the consequence of cost inflation), which may result from passage of the legislation.
- The legislation does not create an unfair market situation for insurers, whereby group policyholders are motivated to self-insure in order to avoid mandated coverage.

- Whenever possible, the need should be met by mandating availability of coverage, rather than mandating inclusion in all plans.[2]

In using these criteria as they apply to this study, two important questions must be asked:

1. What will be the cost impact and how will it affect the marketplace?

2. Is there a need for this insurance coverage which will be resolved with legislation?

Consideration of these two issues may provide a basis for deciding upon possible regulatory approaches: requiring private insurance carriers to provide optional coverage (as is the language of the Select Committee's report and of HCR 84); mandating coverage; or adding additional regulatory or statutory requirements.

One argument against requiring mandated benefit coverage is that it interferes with the free market process, whereby consumers make decisions on the type of health insurance they wish to purchase given their ability to pay. The insurance industry argues that individual consumer decisions are replaced by governmental judgment, which leads to consumers paying for policies that include benefits "they may not want, may never need, and in fact often cannot use."[13] In addition, it is argued that mandating coverage may lead to consumers purchasing narrower and more affordable forms of coverage or, possibly, avoiding the purchase of insurance altogether. In the case of group coverage, insurers argue that mandatory benefits gives groups, usually employers, reason to self fund employee health benefits, contracting with insurers only for claims administration.

Cost Impact: Since 1972, the Texas Legislature has added 12 mandated coverages to the Texas statutes and has considered several others. In view of the recent increases in health care costs generally, and more particularly as they affect insurance programs, in 1983 Speaker Lewis of the Texas House of Representatives issued the following charge to the House Insurance Committee:

> "To study mandated coverage in the health insurance field and to recommend a coherent policy of state mandated coverages. To examine effects of mandated coverages on rates and premiums as well as the impact and utilization and adverse selection when coverages are mandated."4

During late 1983 and throughout 1984, the Insurance Subcommittee on Mandated Coverages closely reviewed the issue of mandated benefits. Three public hearings were held to receive public testimony and to discuss possible recommendations. In its September, 1984 report to the House Insurance Committee, the Subcommittee concluded that ". . . some mandated coverages have the effect of increasing the premiums of policyholders." They also concluded that "government should only interfere with the right of an individual or group to select a health benefit package designed to meet their own needs if intervention is necessary to protect the consumers of this state."[5]

The subcommittee also noted that the trend in Texas towards self-insurance is, in part, due to the increasing number of state health mandates. "Self-insurers escape state law mandates because of the preemption granted by Congress under the Employee Retirement Income Security Act of 1974 (ERISA). The effect of this trend is that the cost of insuring people in the voluntary market increases and the people who are insured through self-insurance plans sometimes have inferior or unstable coverage."[6]

In September 1984, the full House Committee on Insurance adopted the complete report of the Subcommittee on Mandated Benefits. The NAIC criteria for considering mandatory benefits were included in the Insurance Committee's report and offer some guidelines to use in determining the cost impact of a proposal such as mandatory coverage of teenage pregnancy expenses:

> "What is the Cost Impact of this proposal? This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures:
>
> a. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?
>
> b. What are the anticipated fees/rates for the next five years, and how do they compare with alternative providers?
>
> c. What is the estimated increase in insurance premiums for the proposed benefit over the next five years?
>
> d. What is the probable magnitude of the impact of the total health care expenditures?"7

Due to a lack of information concerning the number of pregnant teenagers who are insured under their parents' health insurance coverage, it is impossible to answer these questions with a high degree of accuracy. Even the insurers who already offer the coverage could not in most cases provide any cost estimates. Those that did indicated that the expenses incurred relative to teen pregnancies were almost insignificant. Again, it appears that the high incidence of teen pregnancy among the low economic and uninsured sector has resulted in low utilization of the maternity benefits already available in the market.

## Unmet Need

Approximately 90,000 teen women become pregnant each year in Texas. Past experience indicates that of those adolescent women who carried their pregnancies to term, 34 percent (17,512 in 1982) bore their children out-of-wedlock and thus were potentially placing a financial burden upon their families. The perception of incomplete health care coverage due to a lack of resources was the motivating factor behind the present study.

Research indicates that pregnant teens are less likely than older women to receive proper prenatal care, with the result that their pregnancies are more often subject to complications. Studies suggest that an improvement in the pregnancy outcome will result from an increase in the provision of prenatal care, thereby reducing the health care costs of both mother and child. There are a number of potential sources of providing health care for the unmarried pregnant teen, including parental support, public health care programs, and private health insurance. Little solid research exists on the amount of support that each party provides. Parental resources are hard to identify given that information is not available on the income status of the families of pregnant teens. An additional complicating factor is that unmarried pregnant teens do not always rely upon their parents. Public health care programs exist as a source of care, although they commonly contain income means tests. (Medicaid is a particularly important example of means-tested care, wherein all unmarried dependent minor pregnant teens are eligible for pregnancy-related and newborn care, subject to state implementation of Medicaid guidelines [see Appendix B].)

The NAIC criteria for determining the condition of unmet need asks the following questions:

"Does the new proposal fill an unmet need?

a. What is the current geographical distribution of pertinent providers/health care personnel?

b. What are other alternatives to meeting the identified need?

c. How will the proposed benefit contribute to the quality of patient care and the health status of the populace?

d. Is this a medical or a broader social need, and does it fit in with the role of health insurance?

e. Is proposed mandated benefit legislation advocated by providers or consumers? What are consumer attitudes regarding the need for this legislation?

f. How is the service currently being paid for?

g. What evidence and/or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?"8

Many of the these questions have already been discussed within this report or the report of the Select Committee on Teenage Pregnancy. There is no doubt that good health care is desired for all pregnant mothers to assure a healthy outcome for both mother and child. And, provision of these services varies geographically across the state but is, again, more a reflection of economic differences than a lack of available providers. 'How is the service paid for?' is a question which has already been discussed at length but is difficult to answer with great accuracy due to a lack of conclusive information.

With regard to consumer attitudes concerning the need for this legislation, some recent findings are available. In March 1984, the State Board of Insurance conducted a poll through Texas Insight, regarding their attitudes about regulating the provision of dependent minor pregnancy-related expenses. The survey population was asked their opinion about the following: (1)

requiring all health insurance policies to include this type of coverage, (2) requiring insurers to offer this coverage as an option, and (3) requiring employers to provide their employees with this type of coverage. Table 4.1 shows the design of the survey. Two series of questions were developed on each of these possibilities to test for variability in responses before and after respondents were given some information concerning the problems of teenage pregnancy. There are two factors that need to be considered in interpreting the survey results:

1. The survey questions were developed upon the assumption of the Select Committee that coverage was not available. However, the carrier surveys showed this assumption to be largely incorrect: pregnancy services for dependent daughters are largely available, although the Select Committee was more accurate in its belief that newborn services for grandchildren are largely unavailable.

2. The survey questions asked respondents about coverage for pregnancy-related medical expenses. It is uncertain as to the perception of what was included under the definition of "pregnancy-related" (e.g., does it include newborn care).

Approximately half of the respondents are in favor of mandating coverage of pregnancy-related medical expenses; roughly 38-40 percent are opposed to this requirement (Table 4.1, questions 1 and 4). However, 80-85 percent were in favor of requiring insurance companies to make this coverage available as an option for the buyer. In preferring the option of purchasing this type of insurance as opposed to mandating coverage, consumers may be indicating that they are in favor of the free market allowing for the determination of the type of health benefits made available to particular purchasers. However, there is also the

TABLE 4.1

TEXAS INSIGHT POLL
QUESTIONS RELATED TO TEENAGE PREGNANCY INSURANCE

Currently in Texas, most health insurance policies do not cover pregnancy related medical expenses of teenageers who are covered under their parents' insurance policies.

1. Woul you be in favor of a law requiring all Texas health insurance companies to include pregnancy coverage in all policies sold in Texas?

| | |
|---|---|
| Yes | 49% |
| No | 40% |
| Undecided | 9.4% |

2. Would you be in favor of a law requiring insurance companies to make this kind of coverage available on all health insurance policies, but letting the buyer decide whether or not to purchase it?

| | |
|---|---|
| Yes | 85.3% |
| No | 7.9% |
| Undecided | 4.9% |

3. Would you be in favor of a law requiring those employers who provide health insurance benefits to their employees to provide this kind of coverage?

| | |
|---|---|
| Yes | 65.7% |
| No | 26.2% |
| Undecided | 5.7% |

A study conducted by the Texas legislature showed that more than 50,000 births in 1981 were to teenagers, and of those teenagers only 10.4% received public assistance for their health care, with few being covered by an insurance policy. Given what you know about this issue . . . .

4. Would you be in favor of a law requiring all health insurance policies to include pregnancy related expenses of dependent teenagers in all health insurance policies sold in Texas?

| | |
|---|---|
| Yes | 48.7% |
| No | 38.5% |
| Undecided | 11.1% |

5. Would you be in favor of a law requiring insurance companies to make this coverage available in all health insurance policies but letting the buyer decide whether or not to purchase it?

| | |
|---|---|
| Yes | 80.6% |
| No | 11.7% |
| Undecided | 5.7% |

6. Would you be in favor of a law requiring those employers who provide health benefits to their employees to provide this kind of coverage?

| | |
|---|---|
| Yes | 62.8% |
| No | 28.3% |
| Undecided | 6.8% |

possibility that consumers are responding to the moral implications of teenage pregnancy rather than to the provision of health benefits. There is a common misconception among consumers that most health insurance is purchased on an individual policy basis. In reality, most health insurance is group and employment-related, whereby the individual consumer is not directly involved in the determination of specific benefits to be included under the policy. This misconception is particularly important in reference to attitudes about coverage of teenage pregnancy expenses. Consumers are unlikely to expect a need for purchasing an individual insurance policy that includes health benefits for the consequences of the sexual activities of their daughters. However, the provision of such a benefit as a universal coverage under group policies does not suggest an indictment of the particular habits of any given family. Rather, the availability of such a benefit would address the social problem of adolescent pregnancy. Thus, respondents were asked about requiring employers who provide health benefits to their employees to provide this coverage. Roughly 62-66 percent of respondents were in favor of requiring employers who provide health benefits to their employees to provide this coverage. (Table 4.1, questions 3 and 6) However, there is a possibility that respondents felt more favorable toward employment-related coverage simply because employers would be paying for the coverage in many cases.

But perhaps the most important question posed in the NAIC Criteria is "What evidence is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?" Will legislation providing coverage of teenage pregnancy expenses provide the financial relief that is clearly needed? The results of the SBI surveys of private insurance carriers indicate that pregnancy-related services for dependent minors are already available from a significant number of carriers; newborn care for the offspring of dependent minors is not as widely available.

However, in considering the findings, it must be emphasized that economic constraints make it impossible for lower income families to obtain health insurance. Many of these families are unemployed and uninsured. Many others are employed in low paying jobs where the employee is provided insurance benefits but not the employee's dependents. Since studies indicate that teenage pregnancies tend to occur more frequently among lower income groups, making teen pregnancy coverage available may not necessarily result in a need being met.

Footnotes

[1] National Association of Insurance Commissioners, "Scope of Benefits and Nonduplication of Benefits," Advisory Committee Report, NAIC State and Federal Health Insurance Legislative Policy Task Force, December 1983, NAIC Proceedings, vol.f 1 (1984), 580.

[2] The National Association of Insurance Commissioners, NAIC Proceedings, vol. 1 (1984), 579-580.

[3] Health Insurance Association of America, "Statement of the HIAA to the Texas House Special Study on Mandated Benefits," 3.

[4] Texas House of Representatives, The Committee on Insurance - Subcommittee on Mandated Coverages, Interim Report to the 69th Texas Legislature, September, 1984.

[5] Ibid., 25.

[6] Ibid., 26.

[7] Ibid., 27.

[8] Ibid., 26-27.

## CHAPTER 5

## CONCLUDING OBSERVATIONS

In recommending that this study be conducted, the Select Committee on Teenage Pregnancy was acting on an understanding that insurance coverage for teenage pregnancy expenses was not available. The committee, therefore, asked that the SBI conduct a feasibility study of requiring insurers to provide benefits. The goal was "to reduce the financial burden on parents who have private medical insurance of the costs of pregnancy to a dependent minor, and to insure the optimal pregnancy outcome in these costs."

Based on the findings already reported in this study, there are a number of observations which merit consideration before drawing any final conclusions.

OBSERVATION 1:

H.C.R. 84 specified that this study should look at requiring insurers to provide optional coverage for prenatal, delivery, and pregnancy complication expenses for dependent minors. As discussed in Chapter 3 of this report, pregnancy complication expenses are already required to be covered for insured dependents. If the daughter is listed as a covered dependent under her parent's(s') health insurance policy then by law complication of pregnancy must be covered the same as any other illness. Therefore, it is not necessary to address the inclusion of benefits for pregnancy complications since benefits are already provided.

OBSERVATION 2:

Although H.C.R. 84 did not specify whether this study should focus on individual or group health insurance, it was assumed that group insurance policies only should be considered. The reasons for this have been discussed throughout the report but are summarized below.

1. Very few individual health insurance policies include prenatal and delivery benefits since only those individuals who expect to become pregnant would purchase the benefits. As a result, the premiums for those benefits must be set at a high rate (which would be unaffordable for most individuals) in order for insurers to cover the high number of claims which they would incur.

2. The Federal Pregnancy Discrimination Act prohibits employers of 15 or more employees from discriminating against pregnant women in terms of employment, compensation, and the provision of employee benefits. The Act requires all group health insurance contracts written for employee groups of 15 or more to include insurance benefits for prenatal and delivery costs. (Note: Complications of pregnancy are already required to be covered regardless of the size of the group.) In applying the Act only to employers with 15 or more employees, the inability of small employers to afford such coverage was taken into account. Likewise, this study considers only group policies in order to be consistent with federal and state regulations that deal with pregnancy insurance benefits.

3. Although current figures on the number of Texans with group health insurance are unavailable, it is safe to say that the large majority of insureds have group insurance as opposed to individual policies. This is true across the country since group insurance is more readily available and is usually less expensive than individual policies that offer the same benefits.

4. Because the terms and conditions of individual health policies vary so greatly according to the insured's needs, it was impossible for this agency to do a comprehensive study of both group insurance policy provisions and individual policies. Since group policies cover many more persons than individual policies, a study of group insurance practices provides a broader understanding of the role of insurance and teenage pregnancy.

OBSERVATION 3:

H.C.R. 84 also states that "coverage should be available regardless of who pays the premium, e.g., group employee coverage." Policy conditions are determined on the basis of the type of insurance being written (such as an accident or sickness policy or a Health Maintenance Organization providing group health policies) and are in no way related to the source of premium payments. Insurance contract provisions are not dependent on who pays the premium and benefits are not altered according to whether the employer or an employee is actually paying for the coverage.

OBSERVATION 4:

As discussed in Chapter 3, State Board of Insurance Order 32447 stipulates that insurance policies which provide benefits for prescription drugs must include benefits for prescribed oral contraceptives. However, in conducting the survey of insurance carriers and HMO's, only 16 of the 23 insurance companies and only 9 of the 11 HMO's include benefits for prescribed oral contraceptives. In addition, two of the 16 insurers state that they cover contraceptives only if their use is medically necessary. Thus it appears that there is a lack of consistency in compliance with SBI regulations.

In an effort to obtain compliance with Board Order 32447, a circular letter has been issued to all companies writing accident and health insurance in Texas advising them of the requirement to cover oral contraceptives.

OBSERVATION 5:

In the process of conducting this study, a question was raised concerning the role of the teen father's parent's(s') insurance policy with regard to covering expenses of the newborn child. Assuming that parentage is established, and if the father's parent's(s) policy extends benefits to newborn children of dependents, should coverage apply to the newborn expenses of the teen father's offspring?

Although neither H.C.R. 84 or the Select Committee on Teenage Pregnancy raised this issue, it is a question that merits some consideration. Unfortunately, there is no easy answer. Under current insurance policy contract provisions, the definition of "dependent" varies from one policy to the next. Because this has created problems in the past

the Insurance Board is recommending to the 69th Texas Legislature the adoption of legislation which would provide a standard definition of dependents in all accident and sickness insurance policies. But given the current variance in contract provisions, claim payment decisions concerning the fathers parent's(s) insurance must be determined on an individual basis.

A limited legal study of this question showed no single court decision concerning the payment of paternal grandparent's insurance claims for newborn grandchild expenses. This may be an indication that the question has never been raised before. However, without surveying individual companies with regard to their experience it is impossible to make any statement concerning current practices in this area.

Besides the issue of varying policy provisions, there are a number of other problems that are apparent:

1. Most likely, insurers would require some form of proof that the teen son is truly the father of the child. It is uncertain as to whether insurers would require medical certification or simply a statement verifying such from both the teen mother and teen father.

2. If the insurer accepts verification of the baby's parentage, they may require that the newborn meet their standards of dependency before paying any claims. This could mean in some cases that the father must legally adopt the child or at least assume legal responsibility before the insurance would be activated. Given the nature of most teen pregnancies, it is probably unrealistic to expect the father to take such action simply to obtain insurance benefits for the baby in most cases.

Providing that these questions can be answered (i.e. paternity is established and the father of the child is an eligible dependent under his parent's(s') policy), then it is the opinion of the State Board of Insurance that newborn coverage should be extended to any eligible grandchildren in policies that provide newborn coverage under the provision of Article 3.70-2(E). If both maternal and paternal grandparents' policies' provide benefits then coordination of benefits should be determined accordingly.

OBSERVATION 6:

The third condition of coverage included in H.C.R. 84 states:

> "This coverage should extend to the newborn for the first thirty days of life, just as it does with newborns of policyholders; i.e., it should cover the first thirty days of life on the grandchild of the policyholder."

As discussed in Chapter 3, the extension of benefits to newborns is an issue which has been addressed previously by the Texas Legislature. Article 3.70-2(E) of the Texas Insurance Code states that any accident and sickness insurance policy which provides for accident and sickness coverage of additional newborn children or maternity benefits cannot exclude or limit initial coverage of a newborn infant for a period of time or for congenital defects of a newborn child. Since this statute does not specify that the newborn child must be a child of the policyholder, then it appears that the statute also requires coverage on the newborn child of an insured dependent minor.

In the SBI survey of health insurers in Texas, 19 insurance carriers stated that they do provide dependent minor pregnancy benefits. However, only seven of the 19 carriers also provide the required coverage to newborns of the dependent minors. Thus it appears that there is some confusion among insurers with regard to Article 3.70-2(E).

To assure compliance with the newborn coverage provisions in Article 3.70-2(E), the Board has issued a circular letter to all accident and health insurance companies in Texas advising them of the requirement to provide newborn benefits for the grandchild of the policyholder if maternity benefits for dependent daughters are provided.

OBSERVATION 7:

In both the Select Committee on Teenage Pregnancy's recommendation and in H.C.R. 84, the purpose of this proposed study was to require carriers to provide optional coverage for pregnancy expenses of dependent minors. The study does not address the issue of mandating coverage as opposed to mandating optional coverage. Therefore, this report has not attempted to address this subject in any detail. However, it should be pointed out that these options do exist and are available to consider as statutory alternatives.

The issue of mandated coverages/mandated optional coverages is discussed at length in the House Insurance Committee Report on Mandated Coverages (see Appendix I). In this particular case, there are really three possibilities for regulatory action: to mandate coverage, to mandate optional coverage, or to take no regulatory action. Each of these involve a number of debates which reflect upon the

question of how to most effectively carry out the regulatory goal of protecting consumers and producers alike. Mandated coverage, in striving to grant all individuals a given level of benefit coverage, eliminates the decision of each consumer in deciding whether or not there is a need for coverage, It also eliminates the consumer's decision about whether or not to pay the added cost, if any. As a consequence, health care costs may escalate. The alternative argument is that, in situations where a particular type of coverage is not widely available, mandating coverage may result in that coverage being made available to all of those in need.

In Texas, as in most states, there is a hesitation to mandate benefits. Such action may unduly interfere with the continued stability of the insurance industry, which generally operates within a free market framework. Cost inflation may result, particularly if mandated benefits develop into the battles of political special interests. The regulatory alternative of requiring insurers to offer coverage, as an option, offers to avoid these pitfalls. However, there is no guarantee that--in the quest to control costs and to avoid a regulatory nightmare--those in need will in fact receive services. Adverse selection may take place in that the "option" would only be picked by those most likely to use the service. This would certainly entail much higher costs to those selecting coverage given that the cost of coverage would not be spread among a larger number of persons.

Furthermore, the perception of a need for coverage may not be sufficient to encourage selection of coverage. There may be approximately 90,000 teenage pregnancies a year in Texas, but most parents will probably perceive teenage pregnancy as a problem only among the daughters of other

people. This remoteness of concern may also be evident in the process of selecting a group insurance plan, whereby an employer is often the party making the decisions as to which benefits should and should not be included in the employee health insurance package.

The option of not taking regulatory action is also a viable alternative. Given the results of the carrier surveys--whereby pregnancy-related and newborn care coverage is presently being underwritten--the issue may be moot on requiring coverage. There may be no "unmet need." That determination, however, must be made on the entire body of evidence contained in this report as well as in other studies on teenage pregnancy. The issues to consider (e.g., the health and welfare of the pregnant teen and her offspring, the financial burden which may face the family of a pregnant teen, the cost of providing care, the unavailability of health insurance to low income families, and the effect upon the private insurance industry) are interrelated and ultimately involve personal judgments as to the proper role of private insurance in addressing a social concern.

OBSERVATION 8:

The findings of this report indicate that insurance benefits for pregnant dependent minors are available through group insurance policies. However, a large percentage of pregnant teens tend to be in low income families who are not financially able to purchase insurance and who are not provided insurance benefits through an employer. These people will therefore be unaffected by any statutory or regulatory change in mandating benefits for teen pregnancy expenses.

Although H.C.R. 84 does not speak to the problem of the financial inability of individuals to purchase health insurance, other interim studies do. The Task Force on Indigent Health Care recommends in its September 1984 report that "the state should develop strategies to increase the availability of private health insurance". The Texas Research League is presently conducting a study of this problem for the Task Force. However, the Task Force has not yet adopted any specific recommendations concerning insurance for the indigent.

In addition, S.C.R. 19 as passed by the 68th Texas Legislature directs the State Board of Insurance to "study high-risk pools operating in Texas in order to suggest appropriate methods of instituting an assigned risk pool or similar structure for providing health and hospitalization insurance for persons who have diabetes or for families with a family member who has diabetes". That study is also being presented to the 69th Legislature for consideration.

In bringing up this point, the State Board of Insurance is not recommending that an insurance pool be established but is simply stating that this is an option which the Legislature may wish to consider in contemplating solutions to the problems of teenage pregnancy and problems of populations that are addressed in other studies. It should be pointed out, though, that an insurance pool in the purest sense only provides insurance for individuals who are unable to obtain insurance due to a health condition that the insurance market will not insure; it does not necessarily provide an affordable means of purchasing insurance for low income persons/families who cannot otherwise afford to purchase insurance. Since the problems associated with insurance for teen pregnancies are largely due to financial

restrictions, providing concerning affordable insurance would be the primary purpose of establishing a pool. And, in order for a pool to operate successfully for low income persons, the program would require some type of government subsidy to assure affordability.

For a more complete discussion of the feasibility of establishing an insurance pool in Texas, please see the report of the State Board of Insurance entitled "Health Insurance for Diabetes".

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# Appendix A

## Texas State Legislature House of Representatives

A.1 Select Committee on Teenage Pregnancy, Recommendation 5, Insurance Coverage for Dependent Minors

A.2 House Concurrent Resolution 84

RECOMMENDATION 5: Insurance Coverage for Pregnant Minors

Purpose: To reduce the financial burden on parents who have private medical insurance of the costs of pregnancy to a dependent minor, and to insure the optimal pregnancy outcome in these cases.

Recommendation: The State Insurance Board should investigate the feasibility of requiring that all private insurance carriers provide optional coverage for prenatal, delivery and pregnancy complication expenses, in the event of the pregnancy of the dependent minor of the policyholder. A feasibility report should be made to the Legislature.

1. This coverage should be available regardless of who pays the premium, e.g., group employee coverage.
2. This coverage should include all pregnancy related costs, including hospitalization in the event of pregnancy related complications, and routine outpatient prenatal expenses.
3. This coverage should extend to the newborn for the first thirty days of life, just as it does with newborns of policyholders; i.e., it should cover the first thirty days of life of the grandchild of the policyholder.
4. In all cases, this coverage should be available regardless of whether or not the child is placed for adoption.

HOUSE CONCURRENT RESOLUTION

WHEREAS, The House Select Committee on Teenage Pregnancy was established to investigate the problems associated with teenage pregnancy and early parenthood in Texas and to examine the effectiveness of existing policies and programs that deal with teenagers; and

WHEREAS, One of the major problems facing families with a pregnant teenager is that most private medical insurance providers do not cover the pregnancy expenses of dependent minors unless complications requiring hospitalization occur; and

WHEREAS, Medical insurance policies also do not provide coverage for grandchildren so that, regardless of medical needs, babies born to minor children of policyholders will have no insurance coverage; and

WHEREAS, The Select Committee on Teenage Pregnancy has recommended that steps be taken to reduce the financial burden of parents through private medical insurance coverage of the costs of a pregnancy of a dependent minor; now, therefore, be it

RESOLVED by the House of Representatives of the State of Texas, the Senate concurring, That the 68th Legislature hereby request the State Board of Insurance to investigate the feasibility of requiring private medical insurance carriers to provide optional coverage for prenatal, delivery, and pregnancy complication expenses for dependent minor children of policyholders; and, be it further



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RESOLVED, That this feasibility investigation consider coverage that would:

(1) be available regardless of who pays the premium;

(2) include all pregnancy-related costs, including hospitalization and out-patient prenatal expenses;

(3) extend to newborn grandchildren of policyholders for the first 30 days of life, as does coverage of newborn children of policyholders; and

(4) be available whether or not the child is placed for adoption; and, be it further

RESOLVED, That the State Board of Insurance make a complete report of its findings and recommendations to the 69th Legislature before it convenes in January, 1985; and, be it further

RESOLVED, That an official copy of this resolution be prepared and forwarded to the commissioner of the State Board of Insurance as an expression of the sentiment of the 68th Legislature.

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H.C.R. No. 84

W P Hobby
President of the Senate

Gil Lewis
Speaker of the House

I certify that H.C.R. No. 84 was adopted by the House on April 7, 1983, by a non-record vote.

Betty Brannen
Chief Clerk of the House

I certify that H.C.R. No. 84 was adopted by the Senate on May 5, 1983.

Betty King
Secretary of the Senate

APPROVED: May 10, '83
Date

Mark White
Governor

FILED IN THE OFFICE OF THE SECRETARY OF STATE
10:50 A.M. O'CLOCK
MAY 10 1983
Secretary of State

# Appendix B

## Public Expenditures On Teen Pregnancy

Teen mothers are charged with raising children at an age when they are socially and economically unprepared to deal with that responsibility. An unstable environment is created for the teen mother and child given the high proportion of unintended and out-of-wedlock births among teen mothers; low education and job skills (young mothers often drop out of high school in order to bear and raise their children); and the high teenage divorce rate. In 1978, there were approximately 600,000 families headed by women aged 14-25 with children 5 years old or younger. "Two-thirds of these families [were] living below the officially designated poverty level...."

In general, women have increased their role in the labor market, along with their greater role as primary (or sole) breadwinners in the family. The viability of women in the work environment depends, of course, upon their ability to gain and utilize labor skills which will translate into economic returns. However, the occurrence of a teenage pregnancy has a dampening effect upon the education and earning potential of the young mother and her family. As a consequence, teenage mothers often resort to the welfare system as a source of support.

As poverty takes hold, the public assumes a larger role in providing for the costs of teenage pregnancies. These costs include, in the short term, the provision of medical care (i.e., pregnancy-related and newborn care). Beyond childbirth, there are a myriad of income support and maternal and child support services which are intended to deal with the conditions of poverty which often haunt the young mother. This appendix briefly examines public expenditures for pregnancy-related care for pregnant adolescents (prenatal care, delivery, family planning).

[NOTE: Information is not available on public expenditures for newborn care by the age of mother; thus, discussion will be restricted to pregnancy-related care.] Since the purpose of this feasibility study is to seek avenues through which to deal with the significant social problem of teenage pregnancies, it is important to examine the totality of societal resources--public as well as private health insurance. The proposal for private insurance coverage may lead to the reinforcement of family financial resources through the payment of teenage pregnancy medical expenses. This could lead to an improvement in the social bonds of the teen mother's family and thus serve to interrupt a potential situation of welfare dependency for the young mother and her infant.

Furthermore, it is possible that the private insurance market could absorb some of the costs of teenage pregnancies--costs that would have been picked up by the public.

## PUBLIC PROGRAMS FOR PREGNANCY-RELATED CARE

Texas public expenditures for pregnancy-related care are primarily funded by the federal government and include prenatal care, delivery, and family planning.

Pregnancy-related services are provided under the following federal-state programs:

- Title V (Maternal and Child Health Block Grant)
- Title X (Family Planning)
- Title XIX (Medicaid)
- Title XX (Social Services Block Grants)

Maternity care is provided under Titles V and XIX and consists of maternity care clinic services (e.g., prenatal care, diagnostic testing). Public funding for deliveries comes under Title XIX (Medicaid). Tax-supported hospitals normally provide a level of charity care for indigent women, although 65 counties have no tax-supported hospitals with obstetrical/gynecological beds. Family planning refers to contraceptive-related services: "necessary diagnostic examinations and laboratory tests, contraceptive methods, counseling outreach, follow-up, referrals, and treatment of related health conditions." Total public family planning expenditures under these programs--as well as additional funds from private sources, cities, counties, and hospitals--amounted to $34.4 million in 1980, serving an estimated 474,752 Texans. Unfortunately, data are not always readily available on the proportion of funds expended on women under 20 years of age.

Medicaid

In 1981, $7,216,336 million in Medicaid dollars were spent on 5,534 deliveries for adolescent females; 31 percent of Medicaid deliveries were to teenage women, with an average reimbursement of $1,304. The Medicaid program is a federal-state medical assistance program for the poor, authorized under Title XIX of the Social Security Act (1965). Federal and state funds are allocated according to state income.

Eligibility for Medicaid is based upon categorical eligibility, which grants Medicaid if an individual is a client under one of the categorical aid programs: Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI). Teen mothers are eligible for Medicaid

through the AFDC program. Some states have "medically needy" eligibility, which grants benefits to those low income individuals who would be eligible if medical expenses were considered in calculating income eligibility. However, Texas is restricted to the categorical provision only.

The AFDC program is designed to provide cash assistance to families in need of support because of family disruption. The program was originally established in the 1930s to provide aid to families in which there was a "parent's death, disability, or prolonged absence from the home." Most children receiving AFDC benefits at present are in need because of divorce, desertion of a parent, or out-of-wedlock births. "Teen mothers represent approximately 15 percent of all families receiving Aid to Families with Dependent Children (AFDC) benefits in Texas. In May 1981, 14,216 teenage mothers were receiving these pregnancy assistance benefits." In 1975, it is estimated that 50-56 percent of AFDC expenditures went to families in which the mother was a teenager at the time of her first birth. Thirty-seven percent of women 30 and under bore their first children by age 20; however, 71 percent of AFDC mothers bore their first children as teens.

AFDC program eligibility does not specify age requirements for pregnancy benefits under Medicaid--only that the teen mother be "competent." In addition, pregnancy-related services are exempt from cost-sharing requirements, as are services to individuals under 18. As a result of recent changes in the Medicaid program, eligibility for Medicaid now extends to the following groups meeting AFDC income and resources requirements: (1) first-time pregnant women, from medical verification of pregnancy, and (2) pregnant women in two-parent families when the principal bread-winner is unemployed, from medical verification of pregnancy.

Recent changes were also made in "deeming" parental income in establishing AFDC and Medicaid eligibility for pregnant minors. "Beginning October 1, 1984, states would be allowed not to deem the income and assets of parents to be available to their daughters under age 21 for the purpose of determining the daughters' Medicaid eligibility if the daughters are pregnant and do not have legal custody over other children." Prior to this change, the AFDC eligibility test was based upon the income of the unwed teen mother. The offspring of the teen mother was subject to the same restrictions. However, the income test for the offspring was based upon the income of the teen mother, not the income (or in-kind support) of the grandparents of the infant. Most states presently consider grandparents' income in determining eligibility for the daughter but not for the grandchild.

The grandparents are not legally responsible for the teen daughter's child. Forty-three states do not hold grandparents responsible for the grandchild. Thus, it is possible for an unwed expectant teen mother--dependent upon family resources--to have her delivery paid for by Medicaid regardless of her parent's(s') income level.

Title V - Maternal and Child Health

Administered by the Texas Department of Health, Title V of the Social Security Act (the Maternal and Child Health Block Grant) originated "to provide a variety of health services to low income mothers and their children." Prior to the 1981 Omnibus Budget Reconciliation Act (OBRA) of 1981, Title V had a requirement that 6 percent of its funds be expended on family planning services. However, OBRA eliminated that requirement and changed the program over

to a block grant. In 1980, 85 Texas counties were served by Title V health department family planning projects. In 1980, Texas expended $5.4 million of its $18.5 million Title V budget (29.2 percent of the total) on family planning services; services were provided to 77,787 clients, 11 percent of whom were 15-17 years of age. In addition, 8,265 15-17 year old women were served in Title V maternity clinics, representing 18 percent of the maternity caseload.

Title X - Family Planning

Title X of the Public Health Service Act (1970) is solely addressed to family planning services, including funds for "'voluntary family planning services personnel, grants and contracts for services delivery improvement research, and grants and contracts for family planning information and education.'" In 1980, the Texas Department of Health, administrator of Title X, contracted $9.9 million to 29 provider agencies (e.g., Planned Parenthood), which in turn provided services to 149,777 low income persons.

Title XX - Social Services Block Grant

Title XX, the Social Services Block Grant, includes funding for family planning services among its social services. The Texas Department of Human Resources (TDHR) administers Title XX; in 1980, TDHR contracted services out to 79 family planning organizations (e.g., Planned Parenthood, medical schools, local health departments, hospitals). In 1980, $14.8 million served 205,000 patients, approximately 30 percent of whom (60,475) were women under age 20.

## Appendix C

## State-By-State Regulations on Maternity and Complications of Pregnancy

| | Citation | Effective Date | Comments |
|---|---|---|---|
| ALABAMA | | | |
| ALASKA | | | |
| ARIZONA | Rule R4-14-209 | 6/13/77 | Complications of pregnancy same as illness. Cannot deny maternity benefits to insured or prospective insureds purchasing indl K when offered in family Ks. Applies to all Ks delivered or issued for delivery in state; to all existing grp Ks which are amended. |
| ARKANSAS | Reg 19 | 2/1/76 | Complications of pregnancy same as illness. May not apply arbitrary waiting periods to exclude coverage for premature birth when normal maternity included in K. Applies to renewals & grp Ks as amended, including out-of-state grp Ks. |
| | Reg 19§7A (2nd Rev.) | 1/1/82 | Insurer may consider insured's pregnancy on eff. date of K as preexisting condition to the complication of pregnancy. |
| CALIFORNIA | §10119.5<br>§10121<br>T. 10§2560.3(e) | 7/1/76<br>7/1/76<br>1/1/76 | Involuntary complications of pregnancy coverage must be offered in all Ks. Cannot refuse to offer maternity benefits under indl Ks when offered under family Ks. |
| | Labor Code §1420.35 | 1/1/79 | Employer must treat pregnancy, childbirth & related medical conditions as any other temporary disability but need not extend disability leave past 6 wks. for normal pregnancy. |
| | Health & Safety §1367.7<br>Ins. Code §10123.9<br>§11512.16 | 1/1/80 | Grp Ks offering maternity coverage shall offer coverage for prenatal diagnosis of genetic disorders of fetus by diagnostic procedures in cases of high risk pregnancies. Terms & conditions to be agreed upon between insurer & grp policyholder. |

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| | Citation | Effective Date | Comments |
|---|---|---|---|
| COLORADO | §10-8-122<br>§10-16-137<br>§10-16-138<br>§10-17-131 | 1/1/76 | Comolications of pregnancy same as illness. Same maternity coverage & benefits shall be offered to unmarried women as offered married women. Applies to all Ks issued after eff. date & grp Ks on renewal or reinstatement after eff. date. |
| CONNECTICUT | 38-371§1(q) | 1976 | Pregnancy & resulting childbirth or miscarriage as "disease or injury" in state comprehensive health care law. |
| | C. 557§31-126 | 10/1/73 | Unfair labor practice to terminate employment or deny sick pay benefits on basis of pregnancy. |
| DELAWARE | | | |
| DISTRICT OF COLUMBIA | | | |
| FLORIDA | Rule C. 4-43.01(c) | | Cannot deny maternity benefits in indl Ks when comparable family coverage offers maternity benefits. |
| | Rule C. 4-43.01(f) | | Comolications of pregnancy same as illness. |
| GEORGIA | §56-2443 | 7/1/77 | Comolications of pregnancy coverage required in all grp major medical Ks which cover maternity benefits. Applies to grp Ks issued for delivery, amended or renewed after 1/1/78. |
| HAWAII | | | |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| IDAHO | §41-2140<br>§41-2210<br>§41-3438<br>§41-3932<br>§41-4023<br>Reg 31<br>Reg 7 | 1/1/77<br><br><br><br><br>1/1/77<br>3/1/62 | Involuntary complications of pregnancy coverage must be offered in Ks which provide maternity coverage, except indl noncancellable or guaranteed renewable Ks issued or delivered before 1/1/77. (Includes indl, grp, medical expense & disability income.) |
| | §41-2142 | 7/1/83 | All policies, contracts, plans or certificates shall exclude coverage for elective abortion; such exclusion may be waived by endorsement and payment of a premium. Availability of such coverage at option of insurer. |
| ILLINOIS | Rule 26.04 | 7/1/76 | Complications of pregnancy same as illness. Cannot restrict availability of maternity coverages or benefits based upon marital status. Cannot deny maternity coverages to indl who has not purchased dependent or family coverage when maternity coverages are otherwise available. Applies to all Ks, endorsements or riders issued on or after 7/1/76. |
| | Rule 20.07 | 3/1/81 | Indl: complications of pregnancy may not be limited or excluded. |
| INDIANA | | | |
| IOWA | Rule 510-15.50-15.54 (507B) | 4/13/76 | Complications of pregnancy same as illness. Cannot deny available maternity coverage to unmarried female if same K is available to married females. Applies to all Ks delivered or issued for delivery in state on or after 4/13/76 & to all existing grp Ks amended or renewed on or after 4/13/76. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| KANSAS | Reg 40-1-31<br>Bul 1977-3 | 2/15/77 | Complications of pregnancy same as illness. Cannot deny coverages for maternity to single insureds when such benefits are provided to covered spouses. |
| KENTUCKY | H. 299 ('78) | | Elective abortions only by optional rider & addl premium. |
| LOUISIANA | | | |
| MAINE | 24A§2832 | 1975 | Cannot deny maternity benefits to unmarried women policyholders & minor dependents of policyholders with dependent or family coverage when married policyholders & wives of policyholders are provided with maternity coverage. Applies to grp & blanket Ks written or renewed after eff. date of Act; shall include but not be limited to all types & forms of grp insurance issued by indl companies or corps. |
| | §2741 | 1/1/76 | Applies to all Ks & plans issued or renewed after eff. date. |
| MARYLAND | Art. 48A<br>§354 F, G & H<br>§470 H & I<br>§477 I & J | 1975<br>7/1/77 | Maternity coverage to be offered to same extent as hospitalization benefit provided for any covered illness, regardless of marital status. Applies to temporary disability Ks, nonprofit health service plans, indl or family basis policy forms & grp or blanket health insurance Ks. Does not require any insurer to provide benefits for pregnancy or childbirth in any K. |
| | 498§17 | 7/1/77<br>7/1/82 | Employers to treat pregnancy & childbirth as disability for purposes of temporary disability plans. |
| | §470 I<br>§477 J | 1975 | Maternity benefits offered without regard to marital status. |

| | Citation | Effective Date | Comments |
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| MARYLAND (continued) | §477 P | 1977 | Grp & blanket insurers to offer benefits for temporary disability caused by pregnancy or childbirth same as other covered disabilities, except normal pregnancy disabilities may be limitrd to 6 wks. |
| MASSACHUSETTS | §201<br>§202<br>Civil Rights Act | | Employers shall not segregate, classify or otherwise discriminate against person on basis of sex with respect to term, condition of employment including a benefit plan or system. |
| MICHIGAN | §2027 | 4/1/77 | Unfair competition & unfair act or practice: race, color, creed, marital status, residence, age, handicap or lawful occupation. |
| MINNESOTA | §62A.041 | 6/4/71 | Same coverage for maternity provided to unmarried women & minor female dependents as provided to married women including wives of employees choosing dependent family coverage. Applies to indl & grp Ks and to grp A&H Ks issued or renewed after 6/4/71. |
| | C. 363<br>Human Rights Act | 6/3/77 | Unfair employment practice for employer or labor to treat women affected by pregnancy, childbirth or disabilities related to pregnancy differently under fringe benefit programs. |
| | §62D.02 | 8/1/81 | HMOs: elective abortion, except as medically necessary to prevent death of mother, shall not be mandated. |
| MISSISSIPPI | | | |
| MISSOURI | | | |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| MONTANA | | | |
| NEBRASKA | §44-1615.01 | 4/9/81 | Grp & HMOs paid in whole or part by public funds may not cover abortion unless necessary to prevent death of woman or for complications arising from abortion. |
| NEVADA | Reg. M-7 5.3 & 5.6 | 1/1/77 | Complications of pregnancy same as illness. Cannot deny materity coverage to unmarried female insured or prospective insured purchasing an indl K when comparable coverage available to married female insured or prospective insured. Applies to all Ks delivered or issued for delivery in state by any insurer on or after 1/1/77. |
| | §689B.032 | 7/1/77 | Grp or blanket K may not exclude complications of pregnancy. Defines term. |
| NEW HAMPSHIRE | Reg 19§IV.B.6(a)(1) | 1/1/77 | Indl: premature delivery or complications of pregnancy shall be covered within 9 mos. If expected date of delivery is after 9 mos. waiting period. |
| NEW JERSEY | Cir. Ltrs. 75-2 & 76-2 | | Maternity coverage must be made available to single, divorced, separated and widowed women on same basis as offered to married women. |
| | Adm Code §11:1-4.3 | 9/1/76 | Complications of pregnancy same as illness. |
| NEW MEXICO | | | |
| NEW YORK | §162a<br>§164a | 1976 | Complications of pregnancy same as illness. Normal maternity coverage may be limited to 4 days hospital confinement. Note application of PL 95-555 |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| NEW YORK (continued) | C. 843 ('76) | 1/1/77 | Mandates maternity coverage same as other illness in all grp/indl Ks except guaranteed renewable. |
| | §162.5c | 1/1/80 | Grp conversion Ks must contain required maternity benefits & must be same or substantially same as those provided in K specifically approved as indl conversion K by Supt. |
| NORTH CAROLINA | 11NCAC4.0107 | 1977 | Similar to NAIC model sex discrimination reg. Coverage for complications. |
| NORTH DAKOTA | S. 2385 ('79) | 7/1/79 | Prohibits coverage of abortions except by optional rider for which addl premium must be paid & except where abortion necessary to save life of mother. |
| OHIO | §3901.21 (O) | 8/31/76 | If maternity benefits included, must be available to any indl covered by K in connection with family coverage. |
| OKLAHOMA | Rule 72§6.F.(3) | 1/1/82 | Coverage for complications of pregnancy may not be limited or excluded. |
| | Rule 72§7.F.(3) | 1/1/82 | Indl disability income Ks must allow at least one month's coverage for disability arising out of pregnancy, childbirth or miscarriage. |
| OREGON | C. 731§743.037<br>IC-61 | 1973<br>1/1/75 | Must provide same benefits for maternity to unmarried women as provided to married women, including wives of insured persons choosing family coverage. |

| | Citation | Effective Date | Comments |
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| OREGON (continued) | §659.010 to .110 | 10/4/77 | Women affected by pregnancy, childbirth or related medical conditions shall be treated same for all employment related purposes, including receipt of benefits under fringe benefit programs, as other persons not so affected. |
| PENNSYLVANIA | 31PA Cons. Stat. C. 145 | 1977 | Substantially similar to NAIC model sex discrimination reg. |
| | S. 439 ('82) | 12/11/82 | Insurers to make available health & disability Ks which exclude coverage for abortion services except in case of rape or incest at lower premium than Ks with such coverage. |
| RHODE ISLAND | Reg XXIII | 10/9/78 | K may exclude coverage for pregnancy "except for complications of pregnancy." |
| | §36-12-2.1 | 6/30/82 | Ks covering state, city & town employees: abortion coverage prohibited except to prevent death of mother or resulting from rape or incest; no prohibition for complications as result of abortion. |
| SOUTH CAROLINA | | | |
| SOUTH DAKOTA | | | |
| TENNESSEE | C. 0780-1-34.04 | 5/19/76 | Complications of pregnancy same as illness. Maternity benefits, if provided, cannot discriminate on basis of marital status. Applies to Ks issued 1/1/77; G:D, blanket & franchise amended or renewed 6/1/76; K forms filed for approval 6/1/76. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| TEXAS | Bd Order 31704 | 12/1/78 | Complications of pregnancy same as illness. Exceptions or exclusions permitted for normal pregnancy & childbirth. Certain minimum benefits prescribed for maternity coverage if K provides such coverage. Applies to indl basic hospital, medical & surgical expense Ks, hospital indemnity, major medical expense and disability income Ks. |
| UTAH | Reg 80-12§6.F.3 | 1/1/82 | Coverage for complications of pregnancy may not be limited or excluded. |
| | Reg 80-12§7.F.3 | 1/1/82 | Indl disability income Ks must allow at least one month's coverage for disability arising out of pregnancy, childbirth or miscarriage. |
| VERMONT | Bul 49 | 3/1/80 | Marital status in provision of maternity benefits requires coverage of complications of pregnancy. |
| | Bul 54 Rev. | 4/22/81 | State employment act construed to require pregnancy coverage in employer grp plans. |
| VIRGINIA | §38.1-348.9 | 7/1/78 | Grp hospital or major medical Ks shall provide option for obstetrical services same as physical illness generally. |
| | §38.1-348.13 | 7/1/81 | Ks providing benefits for accidents shall include, same as for other covered accidents or accidental injury, benefits for pregnancy following rape which was reported to police within 7 days following occurrence. Time period extended to 180 days in case of rape or incest of female under age 13. |
| | Rule 19§7.F.(3) | 1/1/81 | Coverage for complications of pregnancy may not be limited or excluded. |

| | Citation | Effective Date | Comments |
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| VIRGINIA (continued) | Rule 19§8.E.(3) | 1/1/81 | Indl disability income Ks must allow at least one month's coverage for disability arising out of pregnancy, childbirth or miscarriage. |
| WASHINGTON | WAC 284-50-320 (6) (c) | 3/1/77 | Indl: may not exclude complications of pregnancy. Does not include disability income protection Ks. |
| WEST VIRGINIA | §33-15 & 16 | 7/1/83 | Indl/grp Ks providing maternity coverage must include benefits for birthing centers and care rendered therein by licensed nurse midwives. Dept. interpreting to also require Ks not providing maternity coverage to make above benefits available. |
| WISCONSIN | Rules INS 6.55 | 6/1/76 | Complications of pregnancy same as ill-ness. Applies to all Ks issued after 6/1/76 & grp Ks issued prior thereto upon renewal or amendment. |
| | S. 201 ('81) | 12/6/81 | Grp Ks providing coverage for dependent children and maternity coverage for any indl must provide equivalent maternity coverage for dependent children. |
| WYOMING | | | |

## Appendix D

## Texas Regulation on Complications of Pregnancy

No. 32447

RECORD OF OFFICIAL ACTION
of the
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date JUN 30 1977

Subject Considered:

RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS

General remarks and official action taken:

On this day came on for consideration by the State Board of Insurance the matter of rules to eliminate unfair discrimination based upon sex or marital status in the terms and conditions of insurance policies, in the underwriting criteria of insurers, and in the rates, rating plans, and rating classifications of insurers. A proposed text of said rules along with a request of comments and notice of a public hearing was submitted to the office of the Secretary of State on May 20, 1976, for publication in the Texas Register. The proposed rules appeared in Volume 1, Number 42, dated May 28, 1976, of the Texas Register. A public hearing to hear testimony and to consider said rules was held before the State Board of Insurance on October 29, 1976, in the Hearing Room of the State Highway Building, 11th and Brazos, Austin, Texas.

At such public hearing the staff, members of the insurance industry, and members of the general public presented comments and amendments to the proposed rules. After reviewing the proposed rules, the proposed amendments, and the comments offered at the hearing, the Board is of the opinion that the proposed rules should be adopted with certain amendments.

THEREFORE, premises considered, the State Board of Insurance does hereby order the rules to eliminate unfair discrimination based upon sex or marital status to be adopted as amended and such are hereby adopted to be effective January 1, 1978, as follows:

"UNFAIR COMPETITION AND UNFAIR PRACTICES

"059.21.21.101. PURPOSE. The purpose of these rules is to eliminate unfair discrimination based upon sex or marital status in the terms and conditions of insurance policies, in the underwriting criteria of insurers, and in the rates, rating plans, and rating classifications of insurers.

"059.21.21.102. APPLICABILITY AND SCOPE. These rules apply to all individual, group, or blanket policies, contracts, and certificates of insurance delivered or issued for delivery in this state on or after January 1, 1978.

"059.21.21.103. DEFINITIONS. For the purposes of these rules:

(A) "Policy" shall include any insurance policy, plan, certificate, subscriber agreement, statement of coverage, binder, rider, endorsement, or application, if attached, offered by any person or entity engaged in the business of insurance or Board-regulated prepaid services in this state.

(B) "Insurer" shall include, but not be limited to, all life, health and accident companies, capital stock companies, mutual assessment life insurance companies, statewide mutual assessment corporations, county mutual insurance companies, local mutual aid associations, farm mutual insurance companies, mutual or natural premium life or casualty insurance companies, general casualty companies, Mexican casualty companies, Lloyds, reciprocal or inter-insurance exchanges, non-profit hospital, medical or dental service corporations including, but not limited to companies subject to Chapter 20 of the Insurance Code of 1951, as amended, stipulated premium insurance companies, fidelity, guaranty, and surety companies, title insurance companies, health maintenance organizations, non-profit legal service corporations, and all other organizations, corporations, or persons engaged in the business of insurance, whether or not named above; provided, however, this regulation shall not apply to any society, company or other insurer whose activities are by statute exempt from the regulation of the Board and which are entitled by statute to an exemption certificate from the Board in evidence of their exempt status, nor to fraternal benefit societies.

"059.21.21.104. UNDERWRITING. Availability of any policy may not be denied to an insured or prospective insured on the basis of sex or marital status of the insured or prospective insured. However, nothing contained in this rule shall be construed to prohibit any insurance underwriter or insurance agent requiring the joinder of both spouses as a condition of issuance of any policy of insurance where such joinder is required by any provision of the constitution or laws of the State of Texas.

Specific practices prohibited by this rule shall include, but not be limited to the following:

(A) No insurer may deny coverage to females gainfully employed at home, employed part time, or employed by relatives when that coverage is offered to males similarly employed.

(B) No insurer may deny policy riders to females when the riders are available to males.

(C) No insurer may exclude from prescription drug benefits oral contraceptives when all other prescription drugs are covered.

(D) No insurer may deny, under group policies, coverage to eligible husbands of female employees, when dependent coverage is available to eligible wives of male employees.

(E) No insurer may deny disability income policies to women employed in high risk classifications when coverage is offered to men similarly employed.

(F) No insurer may deny maternity benefits to insureds or prospective insureds purchasing an individual policy when comparable family coverage policies offer maternity benefits.

"059.21.21.105. POLICY TERMS AND CONDITIONS. The amount of benefits payable, or any term, condition, or type of coverage may not be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured. However, nothing in these Rules shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependents' benefits. Specific practices prohibited by this regulation shall include, but not be limited to, the following:

(A) No policy may treat complications of pregnancy differently than any other illness or sickness under the policy. For the purpose of this rule, complications of pregnancy mean:

(1) conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

(2) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

(B) No policy may restrict, reduce, modify, or exclude benefits based solely upon the genital organs of one sex.

(C) No policy may apply arbitrary waiting periods to maternity benefits in such a way as to exclude coverage for premature births when normal maternity benefits are included in the policy. Medical evidence of the prematurity of the baby may reasonably be required.

(D) No disability policy may offer lower maximum monthly benefits to women than to men who are in the same risk classifications.

(E) No disability policy may offer more restrictive basic benefit periods or more restrictive definitions of disability to women than to men. Normal pregnancy is not considered to be a disability.

(F) No policy may establish different conditions by sex as a prerequisite to the exercise of benefit options contained in the policy.

(G) No insurer may limit the scope and/or amount of coverage an insured or prospective insured may purchase based on the insured's or prospective insured's marital status unless such limitation is for the purpose of defining persons eligible for dependents' benefits.

"059.21.21.106. RATES. When rates differ by sex or marital status, the insurer may be required to justify that the differential equitably reflects the difference in the risk assumed. Rates shall be based on a reasonable classification system according to actual or expected loss and expense data where available. In the absence of actual loss and expense data, rates must be based upon reasonable actuarial assumptions. Rates may differ by sex or marital status when approved or promulgated by the Board.

"059.21.21.107. CONTINUANCE OF COVERAGE. In individual policies, if a person loses coverage due to a change in marital status, that person shall be issued a policy which the insurer is then issuing which most nearly approximates the coverage of the policy which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability and will have the same effective date as the policy under which coverage was afforded prior to the change in marital status.

"059.21.21.108. AMENDMENTS. The subject matters covered by these rules treat only a portion of the subject matters contemplated by Article 21.21 of the Texas Insurance Code and are not exhaustive on this subject; therefore, these rules and regulations remain open for corrections and future additions as the needs may arise or procedures require.

"059.21.21.109. SEVERABILITY CLAUSE. If any provision of a rule of these rules or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the rules which can be given effect without the invalid provision or application, and to this end the provisions of each rule are declared to be severable.

"Rule numbers 059.21.21.110 through 059.21.21.119 are reserved for future expansion."

This order shall remain open for the purpose of any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

AND IT IS SO ORDERED.

STATE BOARD OF INSURANCE

PREPARED BY:

GAYLE SWAFFORD, MANAGER
INDIVIDUAL ACCIDENT & HEALTH
POLICY SECTION

JOE CHRISTIE, CHAIRMAN

NED PRICE, MEMBER

DURWOOD MANFORD, MEMBER

RECOMMENDED BY:

WOODY POGUE, MANAGER
POLICY APPROVAL

RECOMMENDED BY:

DOUG BARNERT
ASSISTANT DEPUTY COMMISSIONER
RESEARCH & COMPLIANCE

No. 33-0-5-0

RECORD OF OFFICIAL ACTION
*of the*
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date DEC 15 1977

Subject Considered:

AMENDMENT TO RULE 059.21.21.102 OF THE
RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR
PRACTICES BASED UPON SEX OR MARITAL STATUS

General remarks and official action taken:

On this day, came on for consideration by the State Board of Insurance, the matter of an amendment to Rule 059.21.21.102 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS. Such rule was originally promulgated under Board Order No. 32447 dated June 30, 1977. The Board has been advised that additional time is needed by this agency and the industry to comply with said rules with respect to accident and health insurance policies, contracts and certificates. It is also the opinion of the Board that the compliance with these rules in respect to accident health insurance can be most easily facilitated if they are to be effective on the same date of the Board rules for minimum standards. Furthermore, it is the Board's opinion that such rules should not apply to certificates issued under group policies subsequent to the effective date of the rules when the group policy is in effect prior to the effective date of the rules. Accordingly, the rules are amended to reflect the foregoing intention.

This rule must become effective prior to January 1, 1978, for the change to take place prior to the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS becoming effective. Therefore, the Board is of the opinion that an immiment peril to the public welfare exists and requires the adoption of this amendment on an emergency basis. The Board is of the opinion that this emergency rule should be effective for 120 Days from the date of its filing with the Secretary of State. This rule is adopted under TEX. INS. CODE ANN. art. 21.21 Sec. 22.

THEREFORE, PREMISES CONSIDERED, the State Board of Insurance does hereby adopt amended Rule 059.21.21.102 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS as set out below and orders that such rule be effective for 120 days from its filing with the Secretary of State. Such rule is amended as follows:

"RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR
PRACTICES BASED UPON SEX OR MARITAL STATUS

* * * *

RULE 059.21.21.102 APPLICABILITY AND SCOPE

These rules apply to all individual, group, or blanket policies and contracts, and individual certificates of insurance delivered

or issued for delivery in this State on or after January 1, 1978; except that to the extent these rules apply to group and individual accident and health policies and contracts and individual certificates the effective date is May 1, 1978."

This Order shall remain open for any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

AND IT IS SO ORDERED.

STATE BOARD OF INSURANCE

HUGH C. YANTIS, JR., CHAIRMAN

NED PRICE, MEMBER

DURWOOD MANFORD, MEMBER

Prepared by:

WOODY POGUE-Manager
Policy Approval

GAYLE SWAFFORD-Manager
Individual Accident & Health

JAMES W. NORMAN
Attorney

No. 3341

RECORD OF OFFICIAL ACTION
of the
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date DEC 30 1977

Subject Considered:

AMENDMENT TO BOARD ORDER NO. 32447
RULES TO ELIMINATE UNFAIR COMPETITION AND
UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS

General remarks and official action taken:

On this day, came on for consideration by the State Board of Insurance the matter of an amendment to Rule 059.21.21.107 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS. Such rule was originally promulgated under Board Order No. 32447 dated June 30, 1977.

The Board has been advised that Rule 059.21.21.107 as originally adopted could have the effect of requiring duplication of coverages for insurance losses arising in lines of insurance other than life, accident and health. The intent of said rule was to provide continuity of coverage and not duplication of coverage; therefore, the Board is of the opinion that said rule should be amended to prevent such duplication.

Due to January 1, 1978 being the date after which said rule applies to all insurance policies other than accident and health delivered or issued for delivery in Texas, the Board, in accordance with V.A.T.S. art. 6252-13a, §5(d), finds that there is an imminent peril to the public welfare. Therefore, such amendment is adopted with fewer than thirty (30) days notice on an emergency basis and takes effect on January 1, 1978 with the filing of two certified copies with the Secretary of State. Such rule is effective on and after such date until permanent amendments are adopted or for one hundred and twenty (120) days, whichever is less.

THEREFORE, PREMISES CONSIDERED, the State Board of Insurance does hereby adopt amended Rule 059.21.21.107 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS and such is hereby amended to read as follows:

"RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS

* * * * *

RULE 059.21.21.107 CONTINUANCE OF COVERAGE. In individual policies, if a person loses coverage due to a change in marital status, that person shall be issued a policy which the insurer is then issuing which most nearly approximates the coverage of the policy which was in effect prior to the change in marital status. The new policy will be issued without evidence of insurability and will have the same effective date as the policy under which coverage was afforded prior to the change in marital status. Provided, however, as respects



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insurance other than life, accident and health, the inception date of the policy issued to provide continuity of coverage need not precede the earliest date required to maintain such continuity, and such policy shall have the same expiration date as the policy under which coverage was issued prior to the change in marital status."

This Order shall remain open for any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

AND IT IS SO ORDERED.

STATE BOARD OF INSURANCE

PREPARED BY:

Doyce R. Lee

DOYCE R. LEE, ATTORNEY

HUGH C. YANTIS, JR., CHAIRMAN

NED PRICE, MEMBER

Durwood Manford

DURWOOD MANFORD, MEMBER

No. 33888

RECORD OF OFFICIAL ACTION
of the
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date JUN 6 1978

Subject Considered:

PERMANENT ADOPTION OF AN AMENDMENT TO RULE 059.21.21.102 OF THE RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS

General remarks and official action taken:

On this day, came on for consideration by the State Board of Insurance, the matter of a permanent adoption of an amendment to Rule 059.21.21.102 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS. Such rule was originally promulgated under Board Order No. 32447 dated June 30, 1977 and published in the Texas Register July 26, 1977. After due consideration the Board is of the opinion that the amendment to such rule should be adopted. Such rule is adopted under authority of TEX. INS. CODE ANN. art. 21.21, Section 13. No comments were received opposing the proposed amendment.

THEREFORE, PREMISES CONSIDERED, the State Board of Insurance does hereby adopt amended Rule 059.21.21.102 of the RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS and such is hereby amended to read as follows:

"RULES TO ELIMINATE UNFAIR COMPETITION AND UNFAIR PRACTICES BASED UPON SEX OR MARITAL STATUS

* * * *

RULE 059.21.21.102 APPLICABILITY AND SCOPE

These rules apply to all individual, group and blanket policies and contracts, and individual certificates of insurance delivered or issued for delivery in this state on or after January 1, 1978. They apply to all group certificates issued pursuant to group policies when the group policy is delivered or issued for delivery in this state on or after January 1, 1978. Provided, however, that to the extent these rules apply to group and individual accident and health policies, contracts, and certificates, the effective date is May 1, 1978.

This Order shall remain open for any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

AND IT IS SO ORDERED.

STATE BOARD OF INSURANCE

PREPARED BY:

James W. Norman
JAMES W. NORMAN
ATTORNEY

HUGH C. YANTIS, JR., CHAIRMAN

NED PRICE, MEMBER

DURWOOD MANFORD, MEMBER

## Appendix E

## State-By-State Regulations on Newborn Care

| | Citation | Effective Date | Comments |
|---|---|---|---|
| ALABAMA | §27-19-38 | 4/27/75 | Substantially model bill without notice provision. |
| ALASKA | §21.42.345 | 8/24/75 | Model bill. |
| ARIZONA | §20.1342<br>§20.1402 | 8/8/74 | Substantially model bill. |
| ARKANSAS | §66-3249<br>§66-3250 | 7/1/75 | Substantially model bill without notice provision. |
| | §66-3248 | 7/1/75<br>3/13/81 | Coverage for newborn same as for other family members and shall include coverage for illness, injury, congenital defect, premature birth, tests for hypothryoidism and phenylketonuria as well as any testing of newborns hereafter mandated by law. |
| | §66-3248(1) | 4/4/83 | Insurers and health care plans must pay for routine nursery care and pediatric charges for well newly born child up to five full days in hospital nursery or until mother is discharged from hospital following birth of child, whichever is less. |
| | §66-3248(3) | 3/17/83 | Insured may be required to give notice to insurer of newborn child within 90 days of birth or before next premium due date, whichever is later. |
| CALIFORNIA | §10119<br>Bul. 72-4 | 7/1/72<br>8/4/72 | Model bill by interpretation. |
| COLORADO | §10-8-121<br>§10-16-134<br>§10-17-130 | 7/1/72 | Substantially model bill--elective coverage with regard to indl A&S insurance Ks. |
| CONNECTICUT | §38-174(g) | 10/1/74 | Substantially model bill. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| DELAWARE | 18§3335<br>18§3510 | 11/23/74 | Substantially model bill by interpretation; includes routine care. |
| DISTRICT OF COLUMBIA | Law 3-33<br>Act 3-99 | 10/20/79 | Indl/grp Ks shall include newborn children coverage, including premature birth. Applies to Ks delivered, renewed, amended or reissued after 120 days following eff. date and to children born more than 120 days after eff. date. |
| FLORIDA | §627.6575<br>§627.641* | 4/29/74<br>10/1/80* | Substantially model bill without notice provision; includes premature birth. Includes transportation costs to and from nearest special facility to maximum of $1,000.* |
| GEORGIA | §56-2441 | 11/1/74 | Substantially model bill. |
| HAWAII | 24§431-454<br>S. 868 ('81)* | 6/12/74 | Substantially model bill; excludes Blues. Adds well-baby care.* |
| IDAHO | §41-2140<br>§41-2210 | 7/1/74 | Interpreted as model bill; indl, grp & blanket disability Ks. |
| ILLINOIS | §356(c) | 8/27/75 | Substantially model bill; includes premature birth. |
| INDIANA | C. 5.6<br>§27-8-5.6-2 | 10/1/75 | Model bill. |
| IOWA | T. XX<br>C. 514C.1 | 1/1/75 | Model bill. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| KANSAS | §40-2,102<br>Bul 14 | 7/1/74 | Substantially model bill. |
| KENTUCKY | §304.17-042<br>§304.18-032<br>§304.32-153 | 10/1/76 | Model bill. |
| | §304.17.185<br>§304.18.033 | 10/1/80 | Indl, grp, blanket, HMO, service or indemnity Ks providing maternity benefits shall offer option for routine nursery care for well newly born child for up to 5 full days in hospital nursery. |
| LOUISIANA | T. 22 R.S. 22<br>§215.1 | 7/2/73 | Substantially model bill; grp, family grp, blanket and franchise A&H. |
| | | 9/1/79 | Ks providing coverage for family members shall offer coverage for transportation by ambulance (including airtransport) of newly born to nearest available hospital or neonatal special care unit within state for treatment of illness, injury, congenital defects & complications of premature birth. Ks in force on 9/1/79 have until 9/1/80 to offer such coverage. All other Ks issued more than 90 days after 9/1/79 must comply. |
| MAINE | 24§2319<br>24A§2743<br>24A§2834 | 6/12/75 | Substantially model bill. |
| MARYLAND | §48A-43BA | 1/1/75 | Model bill. |
| MASSACHUSETTS | 175§47C<br>176A§8b | 1/1/75 | Not model bill; includes premature birth; includes adoptive children. |
| MICHIGAN | §500.3403<br>§500.3611 | 3/3/75 | Substantially model bill; excludes Blues. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| MINNESOTA | §62A.042<br>§62C.14 (14) | 1/1/74<br>1971 | Substantially model bill without notice provision. |
| MISSISSIPPI | §83-9-33 | 4/4/74<br>7/1/79* | Model bill; includes transportation of newborn child to and from special facility.* |
| MISSOURI | §376.406 | 8/13/74 | Substantially model bill. |
| MONTANA | §33-22-504 (grp)<br>§33-22-301 (indl)<br>§33-30-1001 | 3/2/74<br>10/1/81 | Interpreted as model. Amended to require immediate coverage of newborn under all indl Ks, including those that do not insure dependents. Insurer may require notice of birth & premium payment to be made within 31 days of birth for newborn coverage to continue beyond first 31 days after birth. |
| NEBRASKA | §44-710.19 | 1/1/76 | Model bill. |
| NEVADA | §689A.043<br>§689B.033<br>§695B.193 | 8/31/75 | Substantially model bill; includes premature birth. Major medical Ks to include necessary transportation costs to nearest specialized treatment center. |
| NEW HAMPSHIRE | RSA 415:22 | 7/5/75 | Substantially model bill. |
| NEW JERSEY | §17:48A-5<br>§17B:26-2g<br>§17B:27-30 | 11/27/75 | Substantially model bill. |
| NEW MEXICO | §59-18-21<br>§59-18-22<br>§59-19-50<br>§59-19-51 | 6/20/75<br>7/1/78 | Substantially model bill; includes, where necessary to protect life of infant, transportation (including airtransport) to nearest available tertiary care facility. All Ks providing maternity coverage on expense incurred basis must provide, where necessary to protect life of infant or mother, |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| NEW MEXICO (continued) | | | coverage for transportation (including air-transport) for medically high-risk pregnant women with impending delivery of potentially viable infant to nearest tertiary care facility for newly born infants. |
| NEW YORK | §164-2(B) (3)<br><br>§162-18 | 1/1/78<br><br>1/1/83 | Family coverage shall provide coverage from moment of birth.<br><br>Grp Ks must make available coverage for preventive and primary care services for dependent child from date of birth through one year of age. |
| NORTH CAROLINA | §58-251.4 | 5/7/73<br>1/1/83 | Substantially model bill; benefits for congenital defects or anomalies shall include but not be limited to all necessary treatment and care for cleft lip or cleft palate. |
| NORTH DAKOTA | §26-03-38.1-.3 | 7/1/79 | Substantially AAP/HIAA model bill. |
| OHIO | §3923.26 | 1/1/75 | Substantially model bill. |
| OKLAHOMA | 36§6058 | 9/1/75 | Model bill. |
| OREGON | 56§743.120 | 1/1/76 | Substantially model bill; excludes Blues. |
| PENNSYLVANIA | C. 2, Art. IX<br>C. 5§1 (40PS771)<br>§2 (40PS§772)<br>§3 (40PS§773)<br>§4 (40PS§774)<br><br>H. 2663 ('82) | 8/1/75<br><br><br><br><br>12/20/82 | Substantially model bill.<br><br><br><br><br>Reimbursement for birthing facilities when services provided by physician, osteopath or nurse midwife. |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| RHODE ISLAND | Reg XXIII | 10/9/78 | Newborn children coverage to same extent as existing children or the insured. |
| SOUTH CAROLINA | §38-35-70 | | Model bill. |
| SOUTH DAKOTA | §58-17-30.2<br>§58-17-30.3<br>§58-17-30.4<br>§58-18-32 | 7/1/76<br>7/1/83<br><br>7/1/77 | Substantially model bill; indl/grp Ks must provide coverage at next anniversary date of K. Indl/subscriber Ks providing coverage for newly born children shall provide coverage for newly adopted children from beginning of 6-month adoption bonding period. |
| TENNESSEE | §56-7-1001 | 4/22/76 | Model bill. |
| TEXAS | Art. 3.70-2(D) | 8/27/73 | Substantially model bill. |
| UTAH | §31.33-2(6) | 5/13/75 | Substantially model bill. |
| VERMONT | 8§4091 | 4/15/75 | Substantially model bill. |
| VIRGINIA | §38.1-348.6 | 7/1/76 | Substantially model bill. |
| WASHINGTON | §48.21.155 (grp)<br>§48.20.430 (indl)<br>§48.44.212<br>§48.46 | 2/16/74<br><br><br>7/24/83 | Substantially model bill without notice provision. Includes HMOs. |
| WEST VIRGINIA | §33-6-32<br><br>§33-15 & 16 | 2/11/75<br><br>7/1/83 | Substantially model bill.<br><br>Indl/grp Ks shall include benefits for birthing centers and care rendered therein by licensed nurse midwives. (Also see Maternity listing.) |

| | Citation | Effective Date | Comments |
|---|---|---|---|
| WISCONSIN | §632.91<br>Reg 3.38 | 6/1/76 | Ks providing coverage for member of insured's family shall provide benefits applicable for children to newly born from moment of birth. |
| WYOMING | §26-20-101 et seq | 5/30/75 | Model bill. |

# Appendix F

## Texas Law and Regulations on Newborn Care

No. 29296

RECORD OF OFFICIAL ACTION
*of the*
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date JUL 17 1975

Subject Considered:

RULES AND REGULATIONS IN RESPECT OF NEWBORN CHILDREN COVERAGE

General remarks and official action taken:

On May 2, 1975, the State Board of Insurance, after notice, held a public hearing on proposed rules and regulations relating to Article 3.70-2(D) added by Acts 1973, 63rd Leg., p. 1076, Ch. 413, §1 which deals with accident and health coverage of newborn children. Based upon the necessity shown in such hearing for the issuance of rules and regulations pertaining to newborn children coverage, the State Board of Insurance does hereby, promulgate the following rules and regulations:

RULES AND REGULATIONS OF THE STATE BOARD OF INSURANCE
in implementation of

Article 3.70-2(D), Texas Insurance Code
(Added by Acts 1973, 63rd Leg., P. 1076, Ch. 413 §1)

(D) No individual policy or group policy of accident and sickness insurance, including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended, delivered or issued for delivery to any person in this state which provides for accident and sickness coverage of additional newborn children or maternity benefits, may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

Section 1. Purpose

The purpose of these Rules and regulations is implementation of Article 3.70-2(D), Texas Insurance Code (added by Acts 1973, 63rd Legislature, P. 1076, Ch. 413 §1) so as to clarify the applicability of Subsection D to insurance policies to be issued in the future and to existing policies.

Section 2. Applicability and Scope

These Rules and Regulations apply to all individual or group policies of accident and sickness insurance (including policies issued by companies subject to Chapter 20, Texas Insurance Code, as amended) delivered or issued for delivery to any

person in this state which provides for either accident and sickness coverage of additional newborn children or for maternity benefits.

Section 3. Effective Date

These Rules and Regulations shall become effective on August 1, 1975.

Section 4. General Rules of Application

1. No individual policy or group policy of accident and sickness insurance which provides for accident and sickness coverage of additional newborn children may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

2. No individual policy or group policy of accident and sickness insurance which provides for maternity benefits may be issued in this state if it contains any provisions excluding or limiting initial coverage of a newborn infant for a period of time, or limitations or exclusions for congenital defects of a newborn child.

3. If the policy provides benefits for newborn children, the benefits shall be at least as comprehensive as the benefits provided under the policy for other children for loss as a result of an accident or sickness.

4. If the policy does not provide benefits for newborn children but does provide maternity benefits, the coverage of additional newborn children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

5. The initial coverage provided newborn children shall continue for a period of at least 31 days. The insurer may require that before the coverage shall continue beyond this initial 31-day period, the policyholder must notify the insurer of the birth of the newborn child and pay any additional premium required to

maintain the coverage in force. Any additional premium required for the initial period of coverage may be charged.

6. Section 2 of Senate Bill 854, 1973 Session of the Texas Legislature, which is the bill which created Article 3.70-2(D), states the following:

> Sec. 2. This Act shall apply to all accident and sickness policies issued or issued for delivery, renewed, extended, or amended in the State of Texas on and after January 1, 1974. The insurer, upon a renewal, extension, or amendment, may charge such additional premiums as are just and reasonable for the additional risk incurred by compliance with this Act. With respect to any policy forms approved by the State Board of Insurance prior to the effective date of this Act, an insurer is authorized to achieve compliance with this Act by the use of endorsements or riders provided such endorsements or riders are approved by the State Board of Insurance as being in compliance with this Act and other provisions of the Texas Insurance Code.

Subsection D applies to policies written before January 1, 1974, if and when such a policy is "renewed, extended or amended" after January 1, 1974. If the provisions of a policy written before January 1, 1974, allow the insurer to renegotiate the terms of the policy after January 1, 1974, or allow the insurer to adjust the premiums charged under the policy after January 1, 1974, and if at the time such renegotiation or adjustment could be accomplished and is accomplished, the policy continues in force or a policy with substantially similar coverage is agreed to by the insured and insurer, then the policy shall be said to have been "renewed, extended or amended" for purposes of Article 3.70-2(D) and the requirements of Article 3.70-2(D) shall attach to the policy.

This Order will remain open for the purpose of any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

STATE BOARD OF INSURANCE

JOE CHRISTIE, Chairman

NED PRICE, Member

DURWOOD MANFORD, Member

PREPARED BY:

William J. Harding
Chief Clerk

No. 30157

RECORD OF OFFICIAL ACTION
*of the*
STATE BOARD OF INSURANCE
AUSTIN, TEXAS

Date DEC 23 1975

Subject Considered:

BOARD ORDER NO. 29296 STYLED
RULES AND REGULATIONS
IN RESPECT OF
NEWBORN CHILDREN COVERAGE

General remarks and official action taken:

On this day, came on for consideration by the State Board of Insurance, the matter of Board Order No. 29296, dated July 17, 1975, styled Rules and Regulations in Respect of Newborn Children Coverage and amendments to said order.

On December 2, 1975, a public hearing was convened before the State Board of Insurance to consider several proposed amendments to Board Order No. 29296, dated July 17, 1975. After reviewing the testimony and evidence presented at the above mentioned hearing, the Board is of the opinion that Board Order No. 29296 should be amended in the manner proposed by the staff.

THEREFORE, premises considered, the State Board of Insurance does hereby order that Board Order No. 29296 dated July 17, 1975, styled Rules and Regulations in Respect of Newborn Children Coverage be amended and such is hereby amended as follows:

"RULES AND REGULATIONS OF THE STATE BOARD OF INSURANCE
in implementation of

Article 3.70-2(D), Texas Insurance Code
(Added by Acts 1973, 63rd Leg., P. 1076, Ch. 413 § 1)

****

"Section 4. General Rules of Application

****

"3. If the policy provides accident and sickness coverage for newborn children, such coverage shall be at least as comprehensive as the coverage provided under the policy for other children for loss as a result of an accident or sickness.

"4. If the policy provides maternity benefits, and included in such benefits are coverages for newborn infants, such policy may not contain any provision excluding or limiting initial coverage of newborn infants for a period of time, or limit or exclude coverage for congenital defects of a newborn child.

****

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"6. ****

"Subsection D applies to any policy except a 'non-cancellable and guaranteed renewable' policy written before January 1, 1974, if such policy is 'renewed, extended or amended' or a rate adjustment could be made after January 1, 1974. If a group policy is written in conjunction with a collective bargaining agreement, such policy shall be considered 'renewed, extended or amended' upon the expiration of any applicable collective bargaining agreement.

"7. Nothing in these rules shall be deemed to extend the provisions of Article 3.70-2(D) to insurance contracts providing benefits only for specified diseases, pure accident policies, disability only policies, or loss of time only policies."

In all other respects, Board Order No. 29296 remains unchanged. This order will remain open for the purpose of any amendments, corrections, additions, or other changes which may be made and ordered by the Board.

AND IT IS SO ORDERED.

STATE BOARD OF INSURANCE

Prepared by:

JOE CHRISTIE, Chairman

HECTOR DE LEON
General Counsel

NED PRICE, Member

DURWOOD MANFORD, Member

Appendix G

Other States Statutes on Dependent Minor
Pregnancy-Related Care

**2741. Maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage required**

All health insurance policies and plans shall provide, at appropriate rates, the same maternity benefits for unmarried women policyholders and the minor dependents of policyholders with dependent or family coverage under the same terms and conditions as such maternity coverage is provided to married policyholders or the wives of policyholders with maternity coverage. This requirement shall apply to all insurance policies and plans issued or renewed after the effective date of this Act. (1975, c. 276, § 2.)

**2832. Maternity benefits for unmarried women certificate holders and the minor dependents of certificate holders with dependent or family coverage required**

All group or blanket health insurance policies and plans shall provide the same maternity benefits for unmarried women certificate holders, and the minor dependents of certificate holders with dependent or family coverage, as is provided married certificate holders with maternity coverage and the wives of certificate holders with maternity coverage. This requirement shall apply to all group or blanket insurance written or renewed after the effective date of this Act, and shall include, but not be limited to, all types and forms of group insurance issued by individual companies or corporations.

(1975, c. 276, § 3; 1979, c. 663, § 146.)

**§ 62A.041 Maternity benefits; unmarried women**

Each group policy of accident and health insurance issued or renewed after June 4, 1971, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents that it provides to married women including the wives of employees choosing dependent family coverage. If an unmarried insured is a parent of a dependent child, each group policy issued or renewed after July 1, 1976, shall provide the same coverage for that child as that provided for the child of a married employee choosing dependent family coverage if the insured elects dependent family coverage.

Each individual policy of accident and health insurance shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried insured is a parent of a dependent child, each individual policy issued or renewed after July 1, 1976, shall also provide the same coverage for that child as that provided for the child of a married insured choosing dependent family coverage if the insured elects dependent family coverage.

For the purposes of this section, the term "maternity benefits" shall not include elective, induced abortion whether performed in a hospital, other abortion facility, or the office of a physician. Added Laws 1971, c. 680, § 1; amended Laws 1973, c. 651, § 1; Laws 1976, c. 121, § 3; Laws 1980, c. 589, § 25.

62C.14

**NONPROFIT HEALTH SERV. PLAN CORPS**

Subd. 5a. Any group subscriber's contract delivered or issued for delivery or renewed in this state after August 1, 1973, shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried subscriber is a parent of a dependent child, each group subscriber's contract delivered or issued for delivery or renewed after July 1, 1976, shall, if the subscriber chooses family coverage, provide the same coverage for that child as that provided for the child of any other subscriber choosing dependent family coverage. Any group contracting for a group subscriber's contract may request that the coverage required by this section be omitted.

An individual subscriber's contract delivered or issued for delivery in this state shall provide the same coverage for maternity benefits to unmarried women and minor female dependents as that provided for married women. If an unmarried subscriber is a parent of a dependent child, each subscriber's individual contract delivered or issued for delivery or renewed after July 1, 1975, shall, if the subscriber chooses dependent family coverage, provide the same coverage for that child as that provided for the child of any other subscriber choosing dependent family coverage.

**§ 162-a. Maternity care coverage under group accident and health policies**

Every policy subject to the provisions of section one hundred sixty-two which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy, provided, however, that such maternity care coverage, other than coverage for complications of pregnancy, may be limited to reimbursement of covered expenses for maternity care for a period of four days of hospital confinement. Maternity care coverage may also be limited to those persons covered under the policy for a period of ten months, or for a lesser period if the pregnancy commenced while the insured was covered by the policy. Such coverage for maternity care shall include the services of a certified nurse-midwife, under qualified medical direction affiliated or practicing in conjunction with a facility licensed pursuant to article twenty-eight of the public health law, but no insurer shall be required to pay for duplicative routine services actually provided by both a certified nurse-midwife and a physician.

**History.**—L.1976, c. 843, § 1; L.1979, c. 671, § 1; L.1982, c. 721, § 1.

**§ 164-a. Maternity care coverage under individual accident and sickness policies**

Every policy subject to the provisions of section one hundred sixty-four which provides hospital, surgical or medical coverage shall provide coverage for maternity care, including hospital, surgical or medical care to the same extent that hospital, surgical or medical coverage is provided for illness or disease under the policy, provided, however, that such maternity care coverage, other than coverage for complications of pregnancy, may be limited to reimbursement of covered expenses for maternity care for a period of four days of hospital confinement. Maternity care coverage may also be limited to those persons covered under the policy for a period of ten months, or for a lesser period if the pregnancy commenced while the insured was covered by the policy. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction affiliated or practicing in conjunction with a facility licensed pursuant to article twenty-eight of the public health law, but no insurer shall be required to pay for duplicative routine services actually provided by both a certified nurse-midwife and a physician.

**History.**—L.1976, c. 843, § 2; L.1979, c. 671, § 2; L.1982, c. 721, § 2.

**§ 253. Subscriber contracts; required and prohibited provisions**

1-a. Every contract subject to the provisions of this article which provides hospital service, medical expense indemnity or both shall provide coverage for maternity care including hospital, surgical or medical care to the same extent that hospital service, medical expense indemnity or both are provided for illness or disease under the contract, provided, however, that such maternity care coverage, other than coverage for complications of pregnancy, may be limited to reimbursement of covered expenses for maternity care for a period of four days of hospital confinement. Maternity care coverage may also be limited to those persons covered under the contract for a period of ten months, or for a lesser period if the pregnancy commenced while the insured was covered by the policy. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction affiliated or practicing in conjunction with a facility licensed pursuant to article twenty-eight of the public health law, but no insurer shall be required to pay for duplicative routine services actually provided by both a certified nurse-midwife and a physician.

AN ACT to create 632.78 (5) of the statutes, relating to maternity coverage for dependent children under group disability insurance policies.

*The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:*

SECTION 1. 632.78 (5) of the statutes is created to read:

632.78 (5) MATERNITY COVERAGE FOR DEPENDENT CHILDREN. Every group disability policy which provides coverage of dependent children and maternity coverage for any individual shall provide maternity coverage for dependent children. Coverage required under this subsection may not be subject to exclusions or limitations which are not applied to other maternity coverage under the policy.

SECTION 2. **Initial applicability.** This act applies to group disability policies issued or renewed on or after the effective date of this act. For purposes of this act, a group disability policy is renewed on a date specified in the policy as a renewal date or when the rate of premium is changed.

Appendix H

Carrier Surveys

# STATE BOARD OF INSURANCE

1110 SAN JACINTO BLVD. AUSTIN, TEXAS 78786

LYNDON L. OLSON, JR., Chairman
WILLIAM P. DAVES, JR., Member
CAROLE KEETON RYLANDER, Member

TOM BOND, Commissioner
ERNEST A. EMERSON, Fire Marshal
JIM NORMAN, Chief Clerk

March 14, 1984

Private Insurance Carriers

During the interim of the 67th Texas Legislature, the Select Committee on Teenage Pregnancy was directed to investigate the problems associated with teenage pregnancy and early parenthood in Texas, and to examine the effectiveness of existing policies and programs which deal with teenagers. In the course of its study, the committee found that most private medical insurance providers do not cover pregnancy expenses of dependent minors of policyholders unless there are pregnancy complications requiring hospitalization, and under no circumstances is the newborn grandchild covered.

In its final report to the Legislature, the Committee recommended that the State Board of Insurance be asked to investigate the feasibility of requiring private insurance carriers to provide optional coverage for prenatal, delivery and pregnancy complication expenses for dependent minors of the policyholder. Subsequently, the 68th Legislature enacted H.C.R. 84 making this request of the Board, and specifically adding that the investigation consider coverage that would:

(1) be available regardless of who pays the premium;
(2) include all pregnancy-related costs, including hospitalization and out-patient prenatal expenses;
(3) extend to newborn grandchildren of policyholders for the first 30 days of life, as does coverage of newborn children of policyholders; and
(4) be available whether or not the child is placed for adoption.

Celebrating One Hundred and Fifty Years - 1836 - 1986

During the past four months, our Research and Information Services division has been gathering information on teenage pregnancies and related costs. Our initial study indicates that very few insurance companies in Texas provide coverage for dependent minor maternity care; however, coverage is available in a few other states. In order to obtain more comprehensive data concerning availability of coverage, we are asking you to complete the enclosed survey.

In drafting the survey, it was intended that these questions should be used as a general guideline to assist companies in providing the information we are seeking. We realize that some of the information requested may not be available, either because coverage is not provided or because data is not refined to the extent necessary to complete the survey. However, any information you can provide with regard to your company's experience in this area will be useful. Please feel free to expand beyond the questions contained in the survey or to provide your information in a more appropriate form.

This request is made under the Board's authority in Article 1.24, V.T.C.S. Insurance Code. Due to time limitations placed on completion of the report, we would appreciate receiving your response no later than April 6, 1984. Your responses should be mailed to Dianne Longley at the address above.

If you have any questions, please contact Ms. Longley in Research and Information Services at 512/475-4285. I thank you for your assistance and cooperation with this study and look forward to hearing from you.

Sincerely,

Carole Keeton Rylander
Member

CKR:DL:ask

Enclosure

Survey of Insurance Availability for
Pregnancy Related Expenses
of Dependent Minors

_____ _____
Name of Company Date Survey Completed

Name(s) and title(s) of respondents(s)

_____

_____

Phone number(s) of respondent(s)

This survey consists of three sections -- one dealing with dependent minor pregnancy-related care, one dealing with newborn care for the offspring of dependent minors, and one dealing with premium rates for both these coverages.

In responding to questions, please provide figures for calendar year 1982, if available; otherwise, use the most recent figures available and indicate the time period being used.

I. DEPENDENT MINOR PREGNANCY-RELATED CARE

1a. Do you currently provide coverage for dependent minor pregnancy-related expenses?

YES ____ NO ____

1b. If coverage is not currently provided, has it been previously available?

YES ____ NO ____

NOTE: If answering YES to Question 1b, please complete the following questions based on the most recent year such coverage was written.

If answering NO to both questions 1a and 1b, please skip to Part II of the survey.

2. Approximately what percentage of your Texas business includes this coverage and how many lives are covered?

_____ _____
Percentage of Business Number of Lives Covered

3. Approximately what percentage of policies which provide this coverage do so:

as part of the basic contract _____

as an option by rider _____

other (please explain) _____

4. Please indicate which of the services below are included in your company's coverage for dependent minor pregnancy-related care:

delivery _____

complications of pregnancy _____

(coverage mandated by Board Order 32447, Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status, 059.21.21.105, attached)

prenatal care _____

diagnostic tests (e.g., aminocentesis, urinalysis, gentic counseling) _____

abortion _____

family planning _____

contraception _____

(oral contraceptive benefits must be provided in a policy which provides for coverage of all other prescription drugs under Board Order 32447, Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status, 059.21.21.104 (c))

Of the above services, please indicate below benefit restrictions, if any (e.g., set dollar benefit level, maximum days, location requirements for the provision of services):

delivery _____

complications of pregnancy _____

prenatal care _____

diagnostic tests _____

abortion _____

family planning _____

contraception _____

5. Approximately how many dependent minor pregnancy-related claims were paid during the most recent year for which information is available?

   Year _____ Number of Claims _____

6. What is the average cost per claim for dependent minor pregnancy-related expenses?

   _____

7. Based on your policy definition of "dependents", at what age do you discontinue coverage of dependent minors? _____

   _____

II. NEWBORN CARE FOR THE OFFSPRING OF DEPENDENT MINORS

1a. Do you currently provide coverage for newborn care for the offspring of dependent minors?

   YES ____ NO ____

1b. If coverage is not provided, has it been previously available?

   YES ____ NO ____

NOTE: If answering YES to Question 1b, please complete the following questions providing information for the most recent year such coverage was written.

If answering NO to both questions 1a and 1b, please skip to Part III of the survey.

2. Approximately what percentage of your Texas business includes this coverage and how many lives are covered?

   _____% _____

   Percentage of Business Number of Lives Covered

3. Approximately what percentage of policies which provide this coverage do so:

   as part of the basic contract _____

   as an option by rider _____

   other (please explain _____

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4. Please indicate which of the services below are included under your company's newborn care coverage for the offspring of dependent minors:

newborn nursery care _____

neonatal intensive care _____

well baby care through infancy _____

Of the above services, please indicate below benefit restrictions, if any (e.g., set dollar benefit levels, maximum days):

newborn nursery care _____

neonatal intensive care _____

well baby care through infancy _____

5. How many claims were paid for coverage of dependent minors' newborn children during the most recent year for which information is available?

Year _____ Number of Claims _____

6. What was the average cost per claim for newborn care for the offspring of dependent minors?

_____

7. What was the average cost per claim for newborn care of dependent minors' offspring for the following services:

newborn nursery care _____

neonatal intensive care _____

well baby care _____

III. PREMIUM RATE INFORMATION

While we realize that premium rates vary greatly according to type of coverage provided, number of policyholders, age of policyholders, etc., it is important that we obtain information on premium costs attributed to (1) coverage of dependent minor pregnancy-related care and (2) newborn care for offspring of dependent minors. Please provide any data available on the cost of these coverages for the most recent year data was collected (indicate which year).

(1) Coverage of dependent minor pregnancy-related care

Year _____

_____

_____

_____

_____

_____

(2) Newborn care for offspring of dependent minors

Year _____

_____

_____

_____

_____

_____

If you have any questions, please contact Dianne Longley at 512/475-4285.

# STATE BOARD OF INSURANCE

1110 SAN JACINTO BLVD. AUSTIN, TEXAS 78786

LYNDON L. OLSON, JR., Chairman
WILLIAM P. DAVES, JR., Member
CAROLE KEETON RYLANDER, Member

TOM BOND, Commissioner
ERNEST A. EMERSON, Fire Marshal
JIM NORMAN, Chief Clerk

March 21, 1984

Health Maintenance Organization

During the interim of the 67th Texas Legislature, the Select Committee on Teenage Pregnancy was directed to investigate the problems associated with teenage pregnancy and early parenthood in Texas, and to examine the effectiveness of existing policies and programs which deal with teenagers. One of the Committee's findings was that most private medical insurance providers do not cover pregnancy expenses of dependent minors of policyholders unless there are pregnancy complications requiring hospitalization, and under no circumstances is the newborn grandchild covered.

In its final report to the Legislature, the Committee recommended that the State Board of Insurance be asked to investigate the feasibility of requiring private insurance carriers to provide optional coverage for prenatal, delivery, and pregnancy complication expenses for dependent minors of the policyholder. Subsequently, the 68th Legislature enacted H.C.R. 84 making this request of the Board, and specifically adding that the investigation consider coverage that would:

(1) be available regardless of who pays the premium;

(2) include all pregnancy-related costs, including hospitalization and out-patient prenatal expenses;

(3) extend to newborn grandchildren of policyholders for the first 30 days of life, as does coverage of newborn children of policyholders; and

(4) be available whether or not the child is placed for adoption.

Celebrating One Hundred and Fifty Years - 1836 - 1986

During the past four months, our Research and Information Services division has been gathering information on teenage pregnancies and related costs. In order to obtain more comprehensive data concerning availability of insurance coverage, we are asking you to complete the enclosed survey. The 25 largest private insurance carriers in Texas are also being surveyed.

In drafting the survey, it was intended that these questions should be used as a general guideline to assist Health Maintenance Organizations (HMO) in providing the information we are seeking. We realize that some of the information requested may not be available, either because coverage is not provided or because data is not refined to the extent necessary to complete the survey. However, any information you can provide with regard to your HMO's experience in this area will be useful. Please feel free to expand beyond the questions contained in the survey or to provide your information in a more appropriate form.

This request is made under the Board's authority in Article 1.24, V.T.C.S. Insurance Code. Due to time limitations placed on completion of the report, we would appreciate receiving your response no later than April 13, 1984. Your responses should be mailed to Dianne Longley at the address above.

If you have any questions, please contact Ms. Longley in Research and Information Services at 512/475-4285. I thank you for your assistance and cooperation with this study and look forward to hearing from you.

Sincerely,

Carole Keeton Rylander
Member

CKR:DL:ask

Enclosure

Survey of Insurance Availability for
Pregnancy Related Expenses
of Dependent Minors

_____ _____
Name of HMO Date Survey Completed

Name(s) and title(s) of respondents(s)

_____

_____

Phone number(s) of respondent(s)

This survey consists of three sections -- one dealing with dependent minor pregnancy-related care, one dealing with newborn care for the offspring of dependent minors, and one dealing with premium rates for both these coverages.

In responding to questions, please provide figures for calendar year 1983, if available; otherwise, use the most recent figures available and indicate the time period being used.

I. POPULATION CHARACTERISTICS

1. What was your total enrollment, including dependents, as of December 31, 1983?

_____

2. What is your organization's definition of a dependent minor? (e.g., at what age and under what conditions is dependency established and discontinued?)

_____

_____

_____

_____

3. How many of your female members are:

Ages 12 - 14 years old _____

Ages 15 - 17 years old _____

Ages 18 - 19 years old _____

4. Based upon your definition of dependent minors, what percentage of your female members are classified as female dependent minors?

Ages 12 - 14 years old _____

Ages 15 - 17 years old _____

Ages 18 - 19 years old _____

II. DEPENDENT MINOR PREGNANCY-RELATED CARE

1a. Do you currently provide coverage for dependent minor pregnancy-related expenses?

YES ____ NO ____

1b. If coverage is not currently provided, has it been previously available?

YES ____ NO ____

NOTE: If answering YES to Question 1b, please complete the following questions based on the most recent year such coverage was written.

If answering NO to both questions 1a and 1b, please skip to Part III of the survey.

2. Please indicate which of the services below are included in your organization's coverage for dependent minor pregnancy-related care:

delivery _____

complications of pregnancy _____

(coverage mandated by Board Order 32447, Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status, 059.21.21.105, attached)

prenatal care _____

diagnostic tests (e.g., aminocentesis, urinalysis, gentic counseling) _____

abortion _____

family planning _____

contraception _____

(oral contraceptive benefits must be provided in a policy which provides for coverage of all other prescription drugs under Board Order 32447, Rules to Eliminate Unfair Competition and Unfair Practices Based Upon Sex or Marital Status, 059.21.21.104 (c))

Of the above services, please indicate below benefit restrictions, if any (e.g., set dollar benefit level, maximum days, location requirements for the provision of services):

NOTE: If your organization has high and low option benefit plans, please identify the appropriate copayments/deductibles for each benefit plan.

delivery _____

complications of pregnancy _____

prenatal care _____

diagnostic tests _____

abortion _____

family planning _____

contraception _____

5. Approximately how many dependent minor pregnancy-related cases were processed during the most recent year for which information is available?

Year _____ Number of Cases _____

6. What is the average cost per incident for dependent minor pregnancy-related expenses?

_____

_____

## III. NEWBORN CARE FOR THE OFFSPRING OF DEPENDENT MINORS

1a. Do you currently provide coverage for newborn care for the offspring of dependent minors?

YES ____ NO ____

1b. If coverage is not provided, has it been previously available?

YES ____ NO ____

NOTE: If answering YES to Question 1b, please complete the following questions providing information for the most recent year such coverage was written.

If answering NO to both questions 1a and 1b, please skip to Part IV of the survey.

2. How many newborns of dependent minors were covered for newborn care?

_____

_____

3. Please indicate which of the services below are included under your company's newborn care coverage for the offspring of dependent minors:

newborn nursery care _____

neonatal intensive care _____

well baby care through infancy _____

Of the above services, please indicate below benefit restrictions, if any (e.g., set dollar benefit levels, maximum days):

NOTE: If your organization has high and low option benefit plans, please identify the appropriate copayments/deductibles for each option.

newborn nursery care _____

neonatal intensive care _____

well baby care through infancy _____

4. How many cases were processed for coverage of dependent minors' newborn children during the most recent year for which information is available?

Year _____ Number of Cases _____

5. What was the average cost per incident for newborn care for the offspring of dependent minors?

_____

7. What was the average cost per incident for newborn care of dependent minors' offspring for the following services:

newborn nursery care _____

neonatal intensive care _____

well baby care _____

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III. PREMIUM RATE INFORMATION

While we realize that premium rates vary greatly according to benefits provided, number of members enrolled, age of members, etc., it is important that we obtain information on premium costs attributed to (1) coverage of dependent minor pregnancy-related care and (2) newborn care for offspring of dependent minors. Please provide any data available on the cost of these coverages for the most recent year data was collected (indicate which year).

(1) Coverage of dependent minor pregnancy-related care

Year _____ _____

_____

_____

_____

_____

_____

_____

(2) Newborn care for offspring of dependent minors

Year _____ _____

_____

_____

_____

_____

_____

_____

If you have any questions, please contact Dianne Longley at 512/475-4285.

Please return completed survey to:

Ms. Dianne Longley
Research and Information Services
State Board of Insurance
1110 San Jacinto
Austin, Texas 78786

APPENDIX I

House Insurance
Subcommittee on
Mandated Coverages

HOUSE INSURANCE COMMITTEE REPORT OF THE

SUBCOMMITTEE ON MANDATED COVERAGES

CONCLUSIONS

On June 26, 1984, the Subcommittee on Mandated Coverages conducted a formal meeting to discuss recommendations that the subcommittee would make to the full House Insurance Committee. The subcommittee considered all testimony that had been presented to them. They concluded that some mandated coverages have the effect of increasing the premiums of policyholders. They also concluded that government should only interfere with the right of an individual or group to select a health benefit package designed to meet their own needs if intervention is necessary to protect the consumers of this state.

The subcommittee acknowledged the fact that during the course of receiving testimony, they did not have the opportunity to hear the views of the insurance-buying public. There was no testimony from consumers or consumer organizations. The subcommittee further noted that there was no testimony from the employers or employer groups who

select and purchase the insurance plans that cover their employees and families.

The subcommittee noted that the rapid movement toward self insurance is, in part, prompted by the growing number of state health mandates. Self-insurers escape state law mandates because of the preemption granted by Congress under the Employee Retirement Income Security Act of 1974 (ERISA). The effect of this trend is that the cost of insuring people in the voluntary market increases, and the people who are insured through self-insurance plans sometimes have inferior or unstable coverage. The subcommittee believes that any requirements and minimum standards which are adopted by the Texas Legislature should apply equally to all policyholders in this state.

RECOMMENDATIONS

Based on these considerations, the subcommittee adopted the following guidelines for future mandated benefit legislation which may come before the Committee on Insurance:

1. Does the new proposal fill an unmet need? (The issues to be considered in determining whether there is a clear unmet need include the following:

a. What is the current geographical distribution of pertinent providers/health care personnel?

b. What are other alternatives to meeting the identified need?

c. How will the proposed benefit contribute to the quality of patient care and the health status of the populace?

d. Is this a medical or a broader social need, and does it fit in with the role of health insurance?

e. Is proposed mandated benefit legislation advocated by providers or consumers? What are consumer attitudes regarding the need for this legislation?

f. How is the service currently being paid for?

g. What evidence and/or experience in other states is there to demonstrate the likelihood of achieving the stated objectives of meeting a consumer need?

2. What is the Cost Impact of this proposal? This must be analyzed in terms of additional premium expense to consumers and the impact on total health care expenditures:

a. What is the projected utilization of the service to be covered by the mandated benefit over the next five years?

b. What are the anticipated fees/rates for the next five years, and how do they compare with alternative providers?

c. What is the estimated increase in insurance premiums for the proposed benefit over the next five years?

d. What is the probable magnitude of the impact of the total health care expenditures?

3. Is there Control of Overutilization, and what is the impact on Costs and Fees? Changes in coverage or payment of new practitioners must be accompanied by measures to minimize unnecessary utilization and excessive growth of costs. This chiefly pertains to payment of new practitioners.

a. How will non-physicians be reimbursed: fee-for-service, costs, or other; and which one minimizes costs?

b. Will the appropriate professional organization maintain a "registry" with standards to assure a high degree of clinical proficiency?

c. Is the quality of services proposed to be offered by non-physician practitioners an acceptable substitute for, or better than, that delivered by a physician?

4. Is the mandated benefit legislation applicable to all payers, including self-insurers?

5. Can the problem be solved by mandating availability of the coverage, rather than mandating inclusion of the coverage in all plans?

In conclusion, we recommend that the Legislature analyze and evaluate existing and proposed mandated benefit legislation using the criteria suggested. Should the legislature determine that the proposed mandated benefit meets the first four criteria, then rather than mandate its


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inclusion in all policies, it should consider mandating its availability.



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# APPENDIX J

## Model Newborn Children Bill



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Statement of Principles Concerning Legislation for Newborn
Children Coverages in Health Insurance Policies
as adopted by
The American Academy of Pediatrics
and
The Health Insurance Association of America

Principle 1. The provisions of the November 21, 1973 Model Newborn Children Bill are not intended to imply, and should not be construed so as to imply, the inclusion of coverages for routine well-baby care services.

Principle 2. Legislation that would mandate the provision of coverage for routine well-baby care services in all health insurance policies generally would not be in the best interests of the insuring public, since to do so without an appropriate healthcare program containing Federal or state subsidies would simply cause health insurance to become priced beyond the reach of a large segment of the population.

Principle 3. Principles 1 and 2 above do not in any way place in question nor reflect any negative position with regard to:

A. the social or medical value of routine well-baby care services or any other health maintenance services that are considered good medical practice by any professional medical group, or,

B. the propriety of seeking to encourage the voluntary provision of well-baby care coverages through negotiation between the purchasers of insurance and insurance carriers, nor the propriety of encouraging the voluntary inclusion of coverages for well-baby care under group pre-paid practice plans or comprehensive health maintenance organization plans.

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MODEL NEWBORN CHILDREN BILL

Prepared by the American Academy of Pediatrics
with the Assistance of
The Health Insurance Association of America

November 21, 1973

All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued by a nonprofit corporation which provide coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contact may require that notification of birth of a newly born child and payment of the required premium or fees must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31 day period.

The requirements of this act shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than 120 days after the effective date of the act.

National Association of Insurance Commissioners, 1974 Proceedings, Volume 1, 425-426.